

Nebraska Law Review

Volume 95 | Issue 3

Article 2

2017

ERISA Subrogation After *Montanile*

Colleen E. Medill

University of Nebraska College of Law, cmmedill2@unl.edu

Alyssa M. Stokes

University of Nebraska College of Law

Follow this and additional works at: <https://digitalcommons.unl.edu/nlr>

Recommended Citation

Colleen E. Medill and Alyssa M. Stokes, *ERISA Subrogation After Montanile*, 95 Neb. L. Rev. 603 (2016)

Available at: <https://digitalcommons.unl.edu/nlr/vol95/iss3/2>

This Article is brought to you for free and open access by the Law, College of at DigitalCommons@University of Nebraska - Lincoln. It has been accepted for inclusion in Nebraska Law Review by an authorized administrator of DigitalCommons@University of Nebraska - Lincoln.

ERISA Subrogation After *Montanile*

TABLE OF CONTENTS

I. Introduction	604
II. ERISA Subrogation Claims	608
A. The Fiduciary Duties of Plan Administrators	610
B. Reimbursement Claims Against Plan Participants ..	611
1. <i>Great-West Life & Annuity Insurance Co. v. Knudson</i>	612
2. <i>Sereboff v. Mid Atlantic Medical Services, Inc.</i> ..	615
3. <i>US Airways, Inc. v. McCutchen</i>	618
4. <i>Montanile v. Board of Trustees</i>	620
C. The Plan Administrator's Reaction to <i>McCutchen</i> and <i>Montanile</i>	623
III. Post- <i>McCutchen</i> and <i>Montanile</i> Problems	625
A. Disincentives to Litigate Personal Injury Claims or Cooperate with Plan Administrators	625
1. Screen and Decline Borderline Cases	626
2. Attempt to Pre-Negotiate a Set Reimbursement Amount	627
3. Ignore Reimbursement Demand Letters or Provide a Non-Binding Response	629
4. Distribute and Dissipate the Recovered Funds to Avoid an Equitable Lien	632
B. Obstacles to Reimbursement Clause Enforcement ..	632

© Copyright held by the NEBRASKA LAW REVIEW

* Colleen E. Medill is the Robert and Joanne Berkshire Family Professor of Law at the University of Nebraska College of Law and is Of Counsel to Koley Jessen, P.C., L.L.O. Alyssa M. Stokes is a third-year law student at the University of Nebraska College of Law. The authors would like to thank Professor John Lenich of the College of Law faculty for his insights into the federal civil procedure issues addressed in the Article. Early versions of the Article were presented at the invitation of Chief Judge Laurie Smith Camp to the law clerks for federal judges sitting in the District of Nebraska, and to members of the Nebraska Association of Trial Lawyers at the 2016 Nebraska State Bar Association meeting. Their comments and feedback at these presentations were extremely valuable in developing the practical points of federal and state court litigation discussed in the Article. The views presented in the Article are strictly the personal views of the authors and not the views of any institutions with which they are affiliated.

1. Heightened Monitoring (the “letter writing campaign”)	632
2. Intervention in the Participant’s State Court Tort Action	633
3. Injunctive or Declaratory Relief in Federal Court	636
4. Equitable Relief in Federal Court Under Section 502(a)(3)	641
C. Conclusion: An Arbitrary and Inefficient Enforcement System	642
IV. A Targeted Statutory Amendment Solution	643
A. The Proposed Amendment	645
B. Policy Analysis of the Amendment	647

I. INTRODUCTION

Health insurance coverage matters to everyone. It particularly matters to employees, who view employer-sponsored health care insurance as their most important employee benefit.¹ For persons who are not eligible for Medicare, 61% of individuals with health insurance obtain their coverage through a group health plan that is either partially or fully insured by an employer rather than by an insurance company.² These so-called “self-insured” plans universally contain a provision, known as a reimbursement clause, that requires a plan participant to repay medical expenses paid by the plan that are later recovered by the participant from a third party as damages in a personal injury action. The plan document language at issue in *Montanile v. Board of Trustees*,³ the Supreme Court’s 2016 decision involving enforcement of a reimbursement clause, is typical:

Amounts that have been recovered by a [participant] from another party are assets of the Plan . . . and are not distributable to any person or entity without the Plan’s written release of its subrogation interest. . . . “[A]ny amounts” that a participant “recover[s] from another party by award, judgment, settlement or otherwise . . . will promptly be applied first to reimburse the Plan in full for benefits advanced by the Plan . . . and without reduction for attorneys’ fees, costs, expenses or damages claimed by the covered person.”⁴

-
1. Paul Fronstin & Ruth Helman, *Views on the Value of Voluntary Workplace Benefits: Findings from the 2013 Health and Voluntary Workplace Benefits Survey*, 34 EMP. BENEFIT RES. INST. 14, 14 (Nov. 2013), https://www.ebri.org/pdf/notespdf/EBRI_Notes_11_Nov-13_LSDs-WBS.pdf [<https://perma.unl.edu/X362-WMMZ>] (“With the enactment of the Patient Protection and Affordable Care Act of 2010 (PPACA), employees overwhelmingly consider health insurance to be the most important workplace benefit.”).
 2. See *Section Ten: Plan Funding, 2016 Employer Health Benefits Survey*, KAISER FAMILY FOUND. (Sept. 14, 2016), <http://kff.org/report-section/ehbs-2016-section-nine-section-ten-plan-funding/> [<https://perma.unl.edu/3JTF-DV38>].
 3. 136 S. Ct. 651 (2016).
 4. *Id.* at 655.

By enforcing such a reimbursement clause, the plan is able to recover amounts expended for what are usually very large medical bills, thereby helping to keep the cost of coverage under the plan more affordable for the plan's sponsoring employer.⁵

Part II of the Article explains the civil enforcement system for plan reimbursement clauses under the Employee Retirement Income Security Act of 1974⁶ (ERISA), the federal law that exclusively governs reimbursement claims brought by group health plans that are sponsored by private industry employers.⁷ Attempts by ERISA plan administrators to enforce plan reimbursement clauses (known as "ERISA subrogation claims") have resulted in no less than four United States Supreme Court decisions, beginning with *Great-West Life & Annuity Insurance Co. v. Knudson* in 2002,⁸ and ending most recently with *Montanile v. Board of Trustees*.⁹ Part III of the Article analyzes the enforcement problems created by these Supreme Court decisions for injured plan participants, the plaintiffs' personal injury bar, plan administrators, and the state and federal courts. The Article's first claim, presented and developed in Part III, is that all of the players who are involved in ERISA subrogation claim litigation are ill-served by the current enforcement system. Injured plan participants are discouraged from pursuing legitimate damages claims against tortfeasors because the net recovery—after first fully reimbursing the victim's health care plan—may be so minimal that filing a personal injury action is futile.¹⁰ The plaintiffs' personal injury bar is discouraged from providing legal representation to tort victims whose health insurance coverage is provided through an employer's self-insured plan because today's well-drafted plan document will require that the plan must be reimbursed first out of any recovery, in full, for all medical expenses paid by the plan that resulted from the tortfeasor's conduct, without sharing in the litigation costs expended to achieve the

5. See sources cited *infra* note 230.

6. Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 26 & 29 U.S.C.) [hereinafter ERISA].

7. See 29 U.S.C. § 1003 (2012) (defining the scope of ERISA coverage). To simplify the presentation, the Article uses a single private employer who sponsors a single employer plan for its own employees as the governing paradigm for discussion purposes. See 29 U.S.C. § 1002(41) (2012) (defining single employer plan). Reimbursement claims brought by multiemployer plans, which are jointly sponsored by employers and labor unions for collective bargaining unit employees, also are exclusively governed by ERISA. See 29 U.S.C. § 1002(37) (2012) (defining multiemployer plan); *id.* § 1003 (defining scope of ERISA coverage); *id.* § 1132(a)(3)(B)(i)–(ii) (describing civil actions). The enforcement problems and related legal analysis described in the Article are the same for both single employer and multiemployer plan reimbursement claims.

8. See discussion *infra* subsection II.B.1.

9. See discussion *infra* subsection II.B.4.

10. See discussion *infra* subsections II.B.3 & III.A.1.

successful monetary recovery.¹¹ Under current Supreme Court precedent, these plan terms (which may seem inequitable) are enforceable as “appropriate equitable relief” against the plan participant under section 502(a)(3) of ERISA.¹² As a result, the fund recovered from the tortfeasor—either through a pretrial settlement or a jury award—may not even be sufficient to pay the contingency fee earned by the plaintiff-participant’s tort attorney, let alone make the participant whole for her injuries.¹³

As frustrating as ERISA subrogation claims may be for injured plan participants and the plaintiffs’ personal injury bar, the legal labyrinth that plan administrators must navigate to enforce a plan reimbursement clause is equally frustrating. The current civil enforcement system presents numerous practical and procedural obstacles to efficient enforcement.¹⁴ The required monitoring of personal injury claims brought by plan participants against third parties, coupled with uncertain and cumbersome litigation in the federal courts, increase the administrative costs to the employer of sponsoring the health care plan for its employees.¹⁵ For the plan’s administrator, these enforcement actions are not optional. Rather, vigilance is mandated by ERISA’s fiduciary duty standards, which require the plan administrator to act in the best interests of all of the plan’s participants and to prudently administer the plan document according to its terms, including a plan reimbursement clause.¹⁶

Finally, the current enforcement system for ERISA subrogation claims results in the unnecessary waste of state and federal judicial resources.¹⁷ Under ERISA, the federal courts have exclusive jurisdic-

11. See discussion *infra* section II.C.

12. 29 U.S.C. § 1132(a)(3) (2012).

13. See discussion *infra* subsections II.B.3 & III.A.1.

14. See discussion *infra* section III.B.

15. An employer self-insured group health plan operates differently than an insured group health plan, where the insurance company bears the cost of bringing analogous subrogation claims under state insurance laws. See 29 U.S.C. § 1144(b)(2)(A) (saving state laws regulating insurance from preemption). For an employer self-insured plan, the employer bears the administrative costs of the plan, including any costs associated with enforcing a plan reimbursement clause.

16. See 29 U.S.C. § 1104(a)(1)(A), (B), (D). This fiduciary duty to administer the plan in accordance with its terms, including the terms of a reimbursement clause that prohibits application of the common-fund doctrine, is limited to the extent that the terms of the plan are “consistent with the [terms of the fiduciary responsibility provisions of subchapter 4 of title I of ERISA].” 29 U.S.C. § 1104(a)(1)(D). We discuss in subsection III.A.2 of the Article the possibility that a plan administrator may have a fiduciary duty to *disregard* the terms of the plan’s reimbursement clause if negotiating a fee-sharing arrangement with the injured participant’s tort attorney is likely to result in a net recovery of plan assets that is in the best interests of the plan’s participants. See discussion *infra* text notes 143–51 and accompanying text.

17. See discussion *infra* subsections II.B.2–4.

tion over a plan administrator's claim to enforce a reimbursement clause.¹⁸ As a result, it is impossible to adjudicate an ERISA subrogation claim together with what (in the absence of diversity subject matter jurisdiction)¹⁹ is usually a state court tort action. The result is bifurcated litigation, with the plan participant's personal injury claim typically being litigated in state court, and the ERISA subrogation claim to enforce the plan's reimbursement clause against the participant being litigated in federal court.

The Article's second claim, presented in Part IV, is that Congress can resolve these myriad problems through a targeted statutory amendment to ERISA's civil claims and remedies provisions. Such an amendment would reject the Supreme Court's 2013 decision in *US Airways, Inc. v. McCutchen*²⁰ by requiring application of the equity-based common-fund doctrine to ERISA subrogation claims and rendering void as a matter of public policy plan terms to the contrary. The result would be to incentivize personal injury actions by plan participants and to more fairly allocate litigation costs between the injured plan participant and the plan. In return, the proposed amendment would reduce the administrative costs of enforcement for employers by giving state courts concurrent jurisdiction over ERISA subrogation claims and prohibiting removal of ERISA subrogation claims to the federal courts so that such claims could be adjudicated in a single state court forum together with the participant's underlying tort claim. The impact would be to significantly streamline and simplify the enforcement procedure for reimbursement clauses.

Section IV.C of the Article analyzes the policy implications of the proposed statutory amendment. We contend that the many policy benefits of changing the status quo far outweigh the policy objection that a change would undermine ERISA's goal of providing for national uniformity through exclusive federal court subject matter jurisdiction over ERISA subrogation claims. The Article concludes by urging Congress to act in a bipartisan fashion to resolve the problems with ERISA subrogation claims described in Part III of the Article. In light of Congress's failed attempt to repeal the Patient Protection and Affordable Care Act²¹ (Affordable Care Act or ACA), the need for reform in this highly technical area of the law has become more pressing. Notwithstanding the ACA's employer mandate to provide health care in-

18. See 29 U.S.C. § 1132(e)(1).

19. See 28 U.S.C. § 1332 (2012).

20. See discussion *infra* subsection II.B.3.

21. See Mike DeBonis, Ed O'Keefe and Robert Costa, *GOP Health-Care Bill: House Republican Leaders Abruptly Pull Their Rewrite of the Nation's Health-Care Law*, WASH. POST (Mar. 24, 2017), https://www.washingtonpost.com/powerpost/house-leaders-prepare-to-vote-friday-on-health-care-reform/2017/03/24/736f1cd6-1081-11e7-9d5a-a83e627dc120_story.html?utm_term=.3676254df9ea [https://perma.unl.edu/WJ55-Q54R].

surance,²² an employer's decision to offer coverage under a group health plan remains a voluntary decision. Given the voluntary nature of employment-based group health plans, national health care policy should seek to minimize the costs to employers of sponsoring and administering group health plans for their workers. The targeted statutory amendment proposed by the Article is a modest step towards achieving this important public policy objective.

II. ERISA SUBROGATION CLAIMS

The starting point for understanding the legal and practical problems with ERISA subrogation claims is the extent to which ERISA preempts state laws that typically would govern subrogation litigation. As a general rule, section 514(a) of ERISA preempts all state laws that "relate to" an employee benefit plan.²³ Although state insurance laws as applied to *insured* group health plans are saved from ERISA's general preemption provision,²⁴ it has long been the law that employer-sponsored *self-insured* plans are not subject to state insurance law requirements, which include laws that regulate an insurer's subrogation rights against an insured.²⁵ Thus, the federal law of ERISA exclusively controls the enforcement of plan reimbursement clauses found in self-insured group health plans.²⁶

This principle of ERISA preemption originally was established by the Supreme Court in *FMC Corp. v. Holliday*,²⁷ which involved an attempt by a self-insured group health plan to enforce the terms of a reimbursement clause. In *FMC Corp.*, the plan participant was severely injured in an automobile accident and the plan paid for her medical expenses.²⁸ The participant brought a negligence claim against the driver of her automobile in Pennsylvania state court,

22. See 26 U.S.C. § 4890H(a)–(b) (imposing a tax penalty on employers having fifty or more full-time equivalent employees who fail to offer minimum essential health insurance coverage that is affordable for employees).

23. 29 U.S.C. § 1144(a) (2012).

24. See § 1144(b)(2)(A) (savings clause); *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 746–47 (1985).

25. See § 1144(b)(2)(B) (deemer clause); *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990).

26. Although self-insured plans are regulated exclusively by ERISA, employers who desire to control for the risk of catastrophic health care claims can purchase stop-loss insurance, which "insures the plan against claims above a certain dollar amount" (known as the attachment point). See Colleen E. Medill, *HIPAA and Its Related Legislation: A New Role for ERISA in the Regulation of Private Health Care Plans?*, 65 TENN. L. REV. 485, 492 (1998). The existence of stop-loss insurance, even at very low-dollar attachment points, does not transform a self-insured plan into an insured plan that is subject to regulation under state insurance laws. See *id.* at 492–93.

27. 498 U.S. 52 (1990).

28. *Id.* at 55.

which the parties settled. While the negligence action was pending, the employer, acting as the plan's administrator, notified the participant that it would seek reimbursement for the medical expenses paid by the plan.²⁹ The participant countered that a Pennsylvania state insurance law barred the plan's ERISA subrogation claim.³⁰ The Supreme Court disagreed, holding that the Pennsylvania anti-subrogation law, as applied to an employer's *self-insured* plan, was preempted.³¹

Section 502(a) of ERISA lists the types of civil actions permitted under the statute and specifies the remedies available for each particular type of claim.³² Subsection 502(a)(3) authorizes a plan fiduciary to bring a civil action "(A) to enjoin any act or practice which violates any provision of [ERISA] or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of [ERISA] or the terms of the plan."³³ As ERISA's "catch-all" claims provision,³⁴ section 502(a)(3) has been interpreted by the Supreme Court as authorizing a claim by a plan administrator against a plan participant to enforce the terms of a reimbursement clause.³⁵ Importantly, section 502(e)(1) of ERISA gives the federal district courts exclusive subject matter jurisdiction over claims brought under section 502(a)(3).³⁶ It is the exclusive nature of federal court subject matter jurisdiction over ERISA subrogation

29. *Id.*

30. *See id.* at 52–55. The Pennsylvania state law at issue, section 1720 of the Motor Vehicle Financial Responsibility Law, 75 PA. CONS. STAT. § 1720 (1987), provided in relevant part that:

‘in actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant’s tort recovery with respect to . . . benefits . . . payable under section 1719.’ Section 1719 refers to benefit payments by ‘[a]ny program, group contract or other arrangement.’

FMC Corp., 498 U.S. at 55.

31. *FMC Corp.*, 498 U.S. at 65. With respect to an insured plan, the federal courts of appeals are divided concerning whether ERISA completely preempts a participant’s claim, based on a state anti-subrogation law, that seeks to invalidate the terms of an insured plan requiring reimbursement of medical expenses paid by the plan. *See Wurtz v. Rawlings Co.*, 761 F.3d 232, 243–44 (2d Cir. 2014), *cert. denied*, 135 S. Ct. 1400 (2015) (discussing the circuit split between the Second Circuit and the Third, Fourth, and Fifth Circuits). Due to the Supreme Court’s squarely on point decision in *FMC Corp.*, no such division among the federal courts of appeals exists with respect to the enforcement of reimbursement clause terms in self-insured plans.

32. *See* 29 U.S.C. § 1132(a) (2012).

33. 29 U.S.C. § 1132(a)(3).

34. *See Varity Corp. v. Howe*, 516 U.S. 489, 511–12 (1996).

35. *See* discussion *infra* subsection II.B.2.

36. *See* 29 U.S.C. § 1132(e)(1).

claims that is the fundamental source of the problems with reimbursement clause litigation.³⁷

A. The Fiduciary Duties of Plan Administrators

All ERISA fiduciaries, including plan administrators,³⁸ are subject to the fiduciary responsibility provisions set forth in part 4 of title I of ERISA.³⁹ These provisions reflect two underlying policy objectives. ERISA's primary policy objective is to protect the rights of plan participants and their promised plan benefits (the "protective policy").⁴⁰ ERISA's secondary policy objective is to avoid discouraging employers from voluntarily sponsoring benefit plans for their workers by minimizing the administrative burdens and related costs associated with plan sponsorship (the "cost control policy").⁴¹

In crafting ERISA, Congress attempted to strike a balance between these two policy goals, which often are in tension when plan participants desire more or better benefits but employers are reluctant to shoulder the additional costs.⁴² In the reimbursement clause context, however, these policy objectives should—at least in theory—align rather than compete. If an injured plan participant can recoup funds from a third-party tortfeasor as reimbursement for medical expenses paid by the plan, then the pool of plan assets available to pay other participant claims for health care benefits is increased, and the employer's financial obligation to fund those benefits is, either directly or indirectly, reduced.⁴³

Under ERISA's fiduciary responsibility provisions, a fiduciary must "discharge his duties with respect to a plan *solely* in the interest of the participants and beneficiaries and for the *exclusive purpose* of providing benefits to participants and their beneficiaries and de-

37. See discussion *infra* section III.B.

38. Plan administrators are by definition ERISA fiduciaries. See 29 U.S.C. § 1002(16), (21)(A) (2012).

39. See 29 U.S.C. §§ 1101–13 (2012).

40. See *Varity Corp. v. Howe*, 516 U.S. 489, 496–97 (1996); *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 262–63 (1993).

41. See *Mertens*, 508 U.S. at 263 (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 515 (1981) (citing *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 n.17 (1985))).

42. See H.R. REP. NO. 93-533, at 1–2 (1973) ("The primary purpose of the bill is the protection of individual pension rights, but the committee has been constrained to recognize the voluntary nature of private retirement plans. The relative improvements required by this Act have been weighted against the additional burdens to be placed on the system. While modest cost increases are to be anticipated when the Act becomes effective, the adverse impact of these increases have been minimized.").

43. See Roger M. Baron & Anthony P. Lamb, *The Revictimization of Personal Injury Victims by ERISA Subrogation Claims*, 45 CREIGHTON L. REV. 325, 333 & nn.48 & 50 (2012).

fraying reasonable expenses of administering the plan.”⁴⁴ This requirement is known as the exclusive benefit rule or the duty of loyalty. In addition, a plan administrator is required to discharge his duties with respect to the plan “with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.”⁴⁵ This requirement is known as the duty of prudence. Finally, ERISA requires that a plan administrator must discharge his duties with respect to a plan “in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of [ERISA].”⁴⁶ This requirement, known as the duty to follow plan terms, as a general rule includes enforcement of a plan reimbursement clause.⁴⁷

B. Reimbursement Claims Against Plan Participants

Reimbursement claims must be brought in federal district court under section 502(a)(3) as claims for “appropriate equitable relief.”⁴⁸ The nature of “appropriate equitable relief” under section 502(a)(3) was first defined by the Supreme Court in *Mertens v. Hewitt and Associates*.⁴⁹ In *Mertens*, the Supreme Court held that Congress intended “appropriate equitable relief” under section 502(a)(3) to be limited to “categories of relief that were *typically* available in equity (such as injunction, mandamus, and restitution), but not compensatory damages.”⁵⁰ *Mertens* did not involve a reimbursement clause claim, but rather was a claim for damages against a nonfiduciary defendant for participating in a fiduciary’s breach of duty under ERISA.⁵¹ Nine years after *Mertens* was decided, the Supreme Court had its first opportunity to interpret the meaning of “appropriate equitable relief” in the context of a claim for reimbursement in *Great-West Life & Annuity Insurance Co. v. Knudson*.⁵²

44. § 1104(a)(1)(A) (2012) (emphasis added).

45. § 1104(a)(1)(B).

46. § 1104(a)(1)(D).

47. Exceptions to enforcement may apply. See discussion *infra* subsection III.A.2.

48. 29 U.S.C. §1132(a)(3) (2012). See generally John H. Langbein, *What ERISA Means by “Equitable”: The Supreme Court’s Trail of Error in Russell, Mertens, and Great-West*, 103 COLUM. L. REV. 1317 (2003); Colleen E. Medill, *Resolving the Judicial Paradox of “Equitable” Relief Under ERISA Section 502(a)(3)*, 39 J. MARSHALL L. REV. 827 (2006).

49. 508 U.S. 248 (1993).

50. *Id.* at 256.

51. *Id.* at 249.

52. 534 U.S. 204, 210–11 (2002).

1. Great-West Life & Annuity Insurance Co. v. Knudson

In *Great-West*, the primary defendant was a plan beneficiary, Jannette Knudson, who had health insurance coverage through a self-insured plan sponsored by her husband's employer. Knudson suffered a catastrophic injury in an automobile accident that rendered her a quadriplegic.⁵³ Knudson had \$411,157.11 in medical expenses, with the plan's stop-loss insurance carrier, Great-West Life and Annuity Insurance Co. (Great-West), paying for all but the first \$75,000 of Knudson's medical claims. The plan assigned to Great-West the right to enforce the plan's reimbursement clause.⁵⁴

Knudson's attorneys brought various tort claims against the automobile manufacturer and other tortfeasors involved in the accident in California state court.⁵⁵ The parties eventually negotiated a settlement of \$650,000. To preserve Knudson's eligibility for Medicaid under California law, the proposed settlement allocated the funds as follows: \$256,745.30 paid directly to the trustee of a special needs trust set up to pay for Knudson's medical and other needs that would not be covered by Medicaid in the future; \$5,000 to reimburse the California Medicaid program; \$373,426 for attorneys' fees; and \$13,828.70 to reimburse the plan for Knudson's medical expenses.⁵⁶ Notice of this proposed settlement was mailed to Great-West.⁵⁷

One day before the scheduled hearing in state court to approve the negotiated settlement, Great-West filed two actions in federal district court.⁵⁸ First, Great-West attempted to remove the case to federal court. The federal district court determined that removal was improper and remanded the case back to the state district court, which then approved the proposed settlement.⁵⁹ Second, Great-West filed its own claim in federal district court under section 502(a)(3), seeking a declaratory judgment and related injunctive relief to enforce the terms of the plan's reimbursement clause against Knudson.⁶⁰

The Supreme Court described the terms of the plan's reimbursement clause as follows:

The Plan includes a reimbursement provision that is the basis for the present lawsuit. This provides that the Plan shall have the right to recover from the [beneficiary] any payment for benefits" paid by the Plan that the beneficiary is entitled to recover from a third party. Specifically, the Plan has "a first lien upon any recovery, whether by settlement, judgment or otherwise," that the beneficiary receives from the third party, not to exceed "the amount of benefits

53. *Id.* at 207.

54. *Id.*

55. *Id.*

56. *Id.* at 207-08.

57. *Id.* at 207.

58. *Id.* at 208.

59. *Id.*

60. *Id.*

paid [by the Plan] . . . [or] the amount received by the [beneficiary] for such medical treatment” If the beneficiary recovers from a third party and fails to reimburse the Plan, “then he will be personally liable to [the Plan] . . . up to the amount of the first lien.”⁶¹

Pursuant to the terms of the reimbursement clause, Great-West sought to collect the entire \$411,157.11 in medical expenses paid out of the \$650,000 settlement.⁶² In addition, Great-West filed an amended complaint seeking a temporary restraining order to enjoin the settlement approval proceedings in the state trial court.⁶³ The federal district court denied the temporary restraining order, and the state trial court approved the settlement agreement.⁶⁴ Great-West attempted to amend its federal court complaint to add the trustee of the special needs trust and Knudson’s attorney, who held \$256,745.30 and \$373,426, respectively, of the distributed settlement funds, as defendants in pursuing its claim for reimbursement.⁶⁵ The federal district court denied the motion to amend the complaint, and the plan did not appeal the denial of this motion.⁶⁶ After the state court settlement was approved, the federal district court granted summary judgment to Knudson on Great-West’s claim to enforce the reimbursement clause.⁶⁷ Rather than awarding \$411,157.11 in medical expenses, the federal district court held that the recovery under the reimbursement clause was limited to past medical treatment, which the state trial court had determined to be \$13,828.70.⁶⁸ The Ninth Circuit affirmed the grant of summary judgment in favor of Knudson, but on different grounds, holding that a judicial order of reimbursement was not “equitable relief” under section 502(a)(3).⁶⁹

The issue before the Supreme Court in *Great-West* was whether the remedy sought by the plan—essentially seeking specific performance of the contractual obligation to reimburse the plan—could properly be characterized as “appropriate equitable relief” under section 502(a)(3).⁷⁰ Relying on its prior interpretation of the statutory language in *Mertens*, the five-Justice majority in *Great-West* reasoned as follows:

As we explained in *Mertens*, “[e]quitable relief must mean *something less* than *all* relief.” Thus, in *Mertens* we rejected a reading of the statute that would extend the relief obtainable under 502(a)(3) to whatever relief a court of equity is empowered to provide in the particular case at issue (which could in-

61. *Id.* at 207 (citations omitted).

62. *Id.* at 208.

63. *Id.*

64. *Id.*

65. *Id.* at 207–08, 220.

66. *Id.* at 220.

67. *Id.*

68. *Id.* at 208–09.

69. *Id.* at 209.

70. *Id.* at 210.

clude legal remedies that would otherwise be beyond the scope of the equity court's authority). Such a reading, we said, would "limit the relief *not at all*" and render the modifier ['equitable'] superfluous. Instead, we held that the term "equitable relief" in 502(a)(3) must refer to "those categories of relief that were *typically* available in equity"

Here, petitioners seek, in essence, to impose personal liability on respondents for a contractual obligation to pay money—relief that was not typically available in equity. "A claim for money due and owing under a contract is 'quintessentially an action at law.'" "Almost invariably . . . suits seeking (whether by judgment, injunction, or declaration) to compel the defendant to pay a sum of money to the plaintiff are suits for 'money damages,' as that phrase has traditionally been applied, since they seek no more than compensation for loss resulting from the defendant's breach of legal duty." And "[m]oney damages are, of course, the classic form of the classic form of legal relief."⁷¹

The majority in *Great-West* also rejected the plan's argument that the remedy sought should be characterized as "equitable" restitution:

[N]ot all relief falling under the rubric of restitution is available in equity. In the days of the divided bench, restitution was available in certain cases at law, and in certain others in equity . . . [A] plaintiff could seek restitution *in equity*, ordinarily in the form of a constructive trust or an equitable lien, where money or property identified as belonging in good conscience to the plaintiff could clearly be traced to particular funds or property in the defendant's possession. A court of equity could then order a defendant to transfer title (in the case of the constructive trust) or to give a security interest (in the case of the equitable lien) to a plaintiff who was, in the eyes of equity, the true owner. But where "the property [sought to be recovered] or its proceeds have been dissipated so that no product remains, [the plaintiff's] claim is only that of a general creditor," and the plaintiff "cannot enforce a constructive trust of or an equitable lien upon other property of the [defendant]." Thus, for restitution to lie in equity, the action generally must seek not to impose personal liability on the defendant, but to restore to the plaintiff particular funds or property in the defendant's possession.⁷²

These two passages from *Great-West* raised numerous questions that the Supreme Court later answered in *Sereboff*,⁷³ *McCutchen*,⁷⁴ and *Montanile*.⁷⁵ In terms of establishing precedent, *Great-West* made clear that the terms of a reimbursement clause that purported to impose a contractual obligation to reimburse the plan would not be enforced as a personal liability payable from the participant's general assets. In short, *Great-West* established the principle that "appropriate equitable relief" under section 502(a)(3) to enforce a reimbursement clause excluded monetary damages against a breaching participant, and further excluded litigation tactics that would accomplish the same result as a monetary damages award, such as seeking

71. *Id.* at 210 (citations and emphasis omitted).

72. *Id.* at 212–14 (citations omitted).

73. See discussion *infra* subsection II.B.2.

74. See discussion *infra* subsection II.B.3.

75. See discussion *infra* subsection II.B.4.

an injunction or an order of mandamus to compel the payment of money to the plan out of the participant's general assets.⁷⁶

2. *Sereboff v. Mid Atlantic Medical Services, Inc.*

Unlike *Great-West*, *Sereboff v. Mid Atlantic Medical Services, Inc.*⁷⁷ involved a more typical situation where the plaintiffs-participants personally received the bulk of the funds resulting from their state court tort action. The plan's participants, Marlene and Joel Sereboff, were injured in a car accident in California. Their employer self-insured health care plan paid for their medical expenses of \$74,869.37. The Sereboffs filed a personal injury claim in state court, eventually recovering a settlement of \$750,000. Shortly after the personal injury action commenced, and on several occasions over the next two years while the tort litigation was progressing, the plan sent the Sereboffs and their attorney letters asserting a lien on the anticipated proceeds from the lawsuit for the medical expenses paid by the plan. When the lawsuit settled, neither the Sereboffs nor their attorney sent any money to the plan as reimbursement for the medical expenses.⁷⁸

The plan sued the Sereboffs and their attorney in federal district court, bringing a claim under section 502(a)(3) to compel reimbursement for the medical expenses paid by the plan. As described by the Supreme Court, the plan's reimbursement clause provided as follows:

The plan provides for payment of certain covered medical expenses and contains an "Acts of Third Parties" provision. This provision "applies when [a beneficiary is] sick or injured as a result of the act or omission of another person or party," and requires a beneficiary who "receives benefits" under the plan for such injuries to "reimburse [Mid Atlantic]" for those benefits from "[a]ll recoveries from a third party (whether by lawsuit, settlement, or otherwise)." The provision states that "[Mid Atlantic's] share of the recovery will not be reduced because [the beneficiary] has not received the full damages claimed, unless [Mid Atlantic] agrees in writing to a reduction."⁷⁹

Unlike the situation in *Great-West*, and notwithstanding repeated letters from the plan, the tort settlement proceeds in *Sereboff* were distributed before the plan filed its claim in federal court to enforce the reimbursement clause. The plan requested a temporary restraining order and preliminary injunction requiring the Sereboffs to set aside and preserve \$74,869.37 of the distributed settlement proceeds. The parties agreed that the Sereboffs would segregate the funds in an investment account pending a ruling on the merits of the plan's ERISA subrogation claim in federal court and the exhaustion of all appeals.⁸⁰

76. See *Great-West*, 534 U.S. at 210–11.

77. 547 U.S. 356 (2006).

78. *Id.* at 360.

79. *Id.* at 359 (citations omitted).

80. See *id.* at 360.

The federal district court eventually ruled in the plan's favor and ordered the Sereboffs to reimburse the plan. The Sereboffs appealed, and the Supreme Court granted certiorari to resolve a split among the federal courts of appeals regarding the enforceability of reimbursement clause claims as "appropriate equitable relief" under section 502(a)(3).⁸¹

After first reviewing and reaffirming its earlier holdings in *Mertens* and *Great-West*, the Supreme Court distinguished the situation in *Sereboff*:

[I]n this case Mid Atlantic sought "specifically identifiable" funds that were "within the possession and control of the Sereboffs"—that portion of the tort settlement due Mid Atlantic under the terms of the ERISA plan, set aside and "preserved [in the Sereboffs'] investment accounts." Unlike *Great-West*, Mid Atlantic did not simply seek "to impose personal liability . . . for a contractual obligation to pay money." It alleged breach of contract and sought money, to be sure, but it sought its recovery through a constructive trust or equitable lien on a specifically identified fund, not from the Sereboffs' assets generally, as would be the case with a contract action at law. ERISA provides for equitable remedies to enforce plan terms, so the fact that the action involves a breach of contract can hardly be enough to prove relief is not equitable; that would make § 502(a)(3)(B)(ii) an empty promise. This Court in *Knudson* did not reject *Great-West*'s suit out of hand because it alleged a breach of contract and sought money, but because *Great-West* did not seek to recover a particular fund from the defendant. Mid Atlantic does.⁸²

In an unexpected twist, the *Sereboff* Court then turned to a 1914 Supreme Court decision involving a dispute over a contingency fee among three attorneys to establish that a claim to enforce a contractual promise as an equitable lien was a form of "equitable" relief.⁸³ In *Barnes v. Alexander*,⁸⁴ two attorneys named Street and Alexander performed legal work for a third attorney, Barnes, who promised to give them a one-third share of the contingency fee he expected to receive from the case.⁸⁵ When Barnes later refused to pay over the one-third share, they successfully sued in equity to enforce the promise as an equitable lien on the settlement proceeds once the money came into the possession of Barnes.⁸⁶ Reasoning by analogy to the situation in *Barnes v. Alexander*, the Supreme Court held:

[T]he "Acts of Third Parties" provision in the Sereboffs' plan specifically identified a particular fund, distinct from the Sereboffs' general assets—"[a]ll recoveries from a third party (whether by lawsuit, settlement, or otherwise)"—and a particular share of that fund to which Mid Atlantic was entitled—"that portion of the total recovery which is due [Mid Atlantic] for benefits paid." Like Street and Alexander in *Barnes*, therefore, Mid Atlantic could rely on a "familiar rul[e] of equity" to collect for the medical bills it had paid on the

81. See *id.* at 361.

82. *Id.* at 362–63 (citations omitted).

83. *Id.* at 363.

84. 232 U.S. 117 (1914).

85. *Id.* at 119.

86. *Id.* at 123.

Sereboffs' behalf. This rule allowed them to "follow" a portion of the recovery "into the [Sereboffs'] hands" "as soon as [the settlement fund] was identified," and impose on that portion a constructive trust or equitable lien.⁸⁷

The Sereboffs countered that the "strict tracing rules" applicable to a constructive trust under the common law of equity required the plan to show that a specific or identifiable asset owned by or belonging to the plan was being wrongfully held by the Sereboffs, or had been exchanged for other similarly identifiable property.⁸⁸ The Supreme Court distinguished the situation in *Sereboff* because it involved an equitable lien as equitable relief and not a constructive trust:

Barnes confirms that no tracing requirement of the sort asserted by the Sereboffs applies to equitable liens by agreement or assignment: The plaintiffs in *Barnes* could not identify an asset they originally possessed, which was improperly acquired and converted into property the defendant held, yet that did not preclude them from securing an equitable lien. To the extent Mid Atlantic's action is proper under *Barnes*, therefore, its asserted inability to satisfy the "strict tracing rules" for "equitable restitution" is of no consequence.⁸⁹

Finally, the Sereboffs argued that they should be permitted to assert various equitable defenses to the plan's equitable lien, notwithstanding the language of the plan's reimbursement clause that Mid Atlantic's share of the recovery could not be reduced without the plan's written agreement to such a reduction.⁹⁰ The Supreme Court found that "the parcel of equitable defenses the Sereboffs claim . . . are beside the point,"⁹¹ and explained in footnote 2 of the opinion that possible equitable defenses were not considered because their legal counsel failed to make this argument at either the federal district court or appellate court stages of the litigation.⁹²

The Supreme Court's ruling in *Sereboff* was a blow to the plaintiffs' personal injury bar, who remembered in subsequent litigation to assert any and all possible equitable defenses whenever a self-insured group health plan sought to enforce a reimbursement clause. Predictably, the federal circuit courts of appeals became divided over the issue of equitable defenses to a plan's claimed equitable lien.⁹³ In *US*

87. *Sereboff*, 547 U.S. at 364 (citations omitted).

88. *See id.*

89. *Id.* at 365.

90. *See id.* at 368.

91. *Id.*

92. *See id.* at 368 n.2.

93. The Third and Ninth Circuits ruled that equitable defenses could trump the language of a plan reimbursement clause, whereas the Fifth, Seventh, Eighth, Eleventh, and District of Columbia Circuits ruled to the contrary. *See* CGI Techs. & Sols., Inc. v. Rose, 683 F.3d 1113, 1124 (9th Cir. 2012); U.S. Airways v. McCutchen, 663 F.3d 671, 673 (3d Cir. 2011); Zurich Am. Ins. Co. v. O'Hara, 604 F.3d 1232, 1237 (11th Cir. 2010); Admin. Comm. of Wal-Mart Stores, Inc. v. Shank, 500 F.3d 834, 838 (8th Cir. 2007); Moore v. CapitalCare, Inc., 461 F.3d 1, 9–10 (D.C. Cir. 2006); Bombardier Aerospace Emp. Welfare Benefits Plan v. Fer-

Airways, Inc. v. McCutchen,⁹⁴ the Supreme Court revisited and resolved this issue.

3. US Airways, Inc. v. McCutchen

When James McCutchen was injured in a car accident, his employer's self-insured group plan paid \$66,866 in medical expenses arising from the accident.⁹⁵ McCutchen's attorneys were only able to recover \$10,000 from the driver who caused the accident, plus \$100,000 from McCutchen's own insurer, for a total recovery of \$110,000. After deducting attorneys' fees of \$44,000, McCutchen received \$66,000.⁹⁶ The plan demanded reimbursement, which McCutchen refused, but nevertheless his attorneys placed \$41,500 in an escrow account pending resolution of the dispute. This amount represented the plan's claim for reimbursement of the \$66,866 in medical expenses, minus the plan's share of the 40% contingency fee charged by McCutchen's attorneys to secure the recovery.⁹⁷

The plan brought a claim in federal district court against McCutchen under section 502(a)(3) to enforce the reimbursement clause, asserting an equitable lien on the sum of \$66,866, which represented the \$41,500 in the escrow account and an additional \$25,366 that was in McCutchen's possession.⁹⁸ Oddly, the parties litigated the case all the way to the Supreme Court based not on the reimbursement clause language of the plan document itself, but rather on the following language from the plan's summary plan description:

If [US Airways] pays benefits for any claim you incur as the result of negligence, willful misconduct, or other actions of a third party, . . . [y]ou will be required to reimburse [US Airways] for amounts paid for claims out of any monies recovered from [the] third party, including, but not limited to, your own insurance company as the result of judgment, settlement, or otherwise.⁹⁹

The Supreme Court decided that because "everyone in this case has treated the language from the summary description as though it came from the plan, we do so as well."¹⁰⁰

McCutchen countered the plan's claim for an equitable lien with various equitable defenses, which were refined by the time the case reached the Supreme Court down to two specific doctrines designed to prevent unjust enrichment. The Supreme Court described McCutchen's two equitable defenses as follows:

rer, Poirot, & Wansbrough, 354 F.3d 348, 362 (5th Cir. 2003); Admin. Comm. of Wal-Mart Stores, Inc. v. Varco, 338 F.3d 680, 692 (7th Cir. 2003).

94. 133 S. Ct. 1537 (2013).

95. *Id.* at 1543.

96. *Id.*

97. *Id.*

98. *Id.*

99. *Id.*

100. *Id.* at 1543 n.1.

First, [McCutchen] contends that in equity, an insurer in US Airways' position could recoup no more than an insured's "double recovery"—the amount the insured has received from a third party to compensate for the same loss the insurance covered. That rule would limit US Airways' reimbursement to the share of McCutchen's settlements paying for medical expenses; McCutchen would keep the rest (e.g., damages for loss of future earnings or pain and suffering), even though the plan gives US Airways first claim on the whole third-party recovery. Second, McCutchen claims that in equity the common-fund doctrine would have operated to reduce any award to US Airways. Under that rule, "a litigant or a lawyer who recovers a common fund for the benefit of persons other than himself or his client is entitled to a reasonable attorney's fee from the fund as a whole." McCutchen urges that this doctrine, which is designed to prevent freeloading, enables him to pass on a share of his lawyer's fees to US Airways, no matter what the plan provides.¹⁰¹

The Supreme Court emphatically rejected McCutchen's arguments based on its prior precedent in *Sereboff*:

Sereboff's logic dooms McCutchen's effort. US Airways, like Mid Atlantic, is seeking to enforce the modern-day equivalent of an "equitable lien by agreement." And that kind of lien—as its name announces—both arises from and serves to carry out a contract's provisions. So enforcing the lien means holding the parties to their mutual promises. Conversely, it means declining to apply rules—even if they would be "equitable" in a contract's absence—at odds with the parties' expressed commitments.¹⁰²

Continuing with this line of reasoning, the *McCutchen* Court expressly rejected the argument of the Solicitor General, appearing as *amicus curiae*, that the terms of the plan document do not control when equitably apportioning litigation costs based on the common-fund doctrine.¹⁰³ According to the Supreme Court, "if the agreement governs, the agreement governs," without any special exception for the equitable allocation of attorneys' fees.¹⁰⁴

McCutchen did recognize that even though equitable principles cannot trump an express plan term, if the plan document is silent or ambiguous then equitable rules and doctrines may be used as "gap-fillers" to construe the plan's terms as a matter of federal common law.¹⁰⁵ Based on the language of the plan's summary plan description, the Supreme Court found that although the reimbursement language prohibited application of the double-recovery rule, it said "nothing specific" about the payment or allocation of the attorneys' fees incurred to obtain the recovery.¹⁰⁶ Due to this drafting gap, the *McCutchen* Court ruled that "the common-fund doctrine provides the best indication of the parties' intent,"¹⁰⁷ reasoning that "[a] party would not typically expect or intend a plan saying nothing about attor-

101. *Id.* at 1545 (citations omitted).

102. *Id.* at 1546 (citations omitted).

103. *See id.* at 1547.

104. *Id.*

105. *Id.* at 1548.

106. *Id.*

107. *Id.* at 1550.

ney's fees to abrogate so strong and uniform a background rule. And that means a court should be loath to read such a plan in that way."¹⁰⁸

Thus, *McCutchen* answered the question of possible equitable defenses to an equitable lien left unanswered in *Sereboff* by leaving it up to the employer who sponsors the plan. Predictably, employers responded to *McCutchen* by amending the language of their plan documents to preclude application of the make-whole rule, the common-fund doctrine, unjust enrichment-based theories and doctrines, and any other imaginable defense available in a common law court of equity that could possibly be asserted by a plan participant in ERISA subrogation claim litigation.¹⁰⁹

McCutchen left unanswered, however, the second question raised in *Great-West*, namely how strictly the federal courts should construe the Supreme Court's statement that "for restitution to lie in equity, the action generally must seek not to impose personal liability on the defendant, but to restore to the plaintiff particular funds or property in the defendant's possession."¹¹⁰ *Montanile v. Board of Trustees*¹¹¹ answered this question.

4. *Montanile v. Board of Trustees*

Robert Montanile was injured by a drunk driver in an automobile accident. His health care plan paid approximately \$121,044 for his initial medical care after the accident.¹¹² The plan required Montanile to sign a reimbursement agreement "reaffirming" his obligation to reimburse the plan from any recovery he obtained "as a result of any legal action or settlement or otherwise."¹¹³

Montanile sued the driver and obtained a \$500,000 settlement. After paying his attorney \$260,000 in fees and costs, Montanile had sufficient funds to reimburse the plan. His attorney held Montanile's remaining \$240,000 share of the settlement in a client trust account while attempting to negotiate an agreement with the plan concerning

108. *Id.* In a footnote to this passage, the *McCutchen* Court observed that "almost every state court that has confronted the issue has done what we do here: apply the common-fund doctrine in the face of a contract giving an insurer a general right to recoup funds from an insured's third-party recovery, without specifically addressing attorney's fees." *Id.* at 1550 n.8 (citing numerous state court decisions). This almost universal adoption of the common-fund doctrine as a matter of state common law provides strong support for the statutory amendment solution proposed in Part IV of the Article. See discussion *infra* section IV.B.

109. For an exemplar of a post-*McCutchen* plan reimbursement clause, see *infra* section II.C.

110. *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 212–14 (2002).

111. 136 S. Ct. 651 (2016).

112. See *id.* at 655. Montanile was a member of a collective bargaining unit and his coverage was through a multiemployer plan. *Id.*

113. *Id.* at 656.

reimbursement.¹¹⁴ After negotiations broke down, Montanile's attorney warned the plan that he would distribute the \$240,000 to Montanile if the plan did not object within 14 days. The plan did not respond and so the attorney distributed the funds to Montanile, who then spent some or all of the funds (this fact was not definitely resolved at the trial court level) on nontraceable items.¹¹⁵

Six months after the negotiations ended, the plan sued Montanile in federal district court under section 502(a)(3) to enforce the plan's reimbursement clause and recover the \$121,044.02 that the plan had expended for Montanile's medical expenses. The plan sought an equitable lien on any "settlement funds or any property" that remained in Montanile's possession.¹¹⁶ In addition, the plan asked the district court to enjoin Montanile from dissipating any settlement funds in his possession. The district court granted summary judgment to the plan and ruled that the plan was entitled to reimbursement from Montanile's general assets, rejecting the argument that because Montanile had spent almost all of the settlement funds on nontraceable items there was no "specific, identifiable fund" to which an equitable lien could attach.¹¹⁷ The Eleventh Circuit affirmed, and the Supreme Court granted certiorari to resolve a circuit split over whether an equitable reimbursement clause lien could be enforced against a participant's general assets when the participant dissipates the "specific, identifiable fund."¹¹⁸

The *Montanile* Court described the terms of the plan's reimbursement clause as follows:

The plan states: "Amounts that have been recovered by a [participant] from another party are assets of the Plan . . . and are not distributable to any person or entity without the Plan's written release of its subrogation interest." The plan also provides that "any amounts" that a participant "recover[s] from another party by award, judgment, settlement or otherwise . . . will promptly

114. *Id.*

115. *See id.*

116. *Id.*

117. *Id.*

118. *See id.* Prior to *Montanile*, the First, Second, Third, Sixth, and Seventh Circuits had held that an ERISA plan may enforce an equitable lien against a defendant's general assets even if the fund has been dissipated, whereas the Eighth and Ninth Circuits had held that it may not. Compare *Cusson v. Liberty Life Assurance Co.*, 592 F.3d 215 (1st Cir. 2010) (plan may collect from defendant even though the fund was no longer in the defendant's possession or control), *Thurber v. Aetna Life Ins. Co.*, 712 F.3d 654 (2d Cir. 2013) (same), *Funk v. CIGNA Grp. Ins.*, 648 F.3d 182 (3d Cir. 2011) (same), *Longaberger Co. v. Kolt*, 586 F.3d 459 (6th Cir. 2009) (same), and *Gutta v. Standard Select Trust Ins. Plans*, 530 F.3d 614 (7th Cir. 2008) (same), with *Treasurer, Trustees of Drury Indus., Inc. Health Care Plan & Trust v. Goding*, 692 F.3d 888 (8th Cir. 2012) (when the defendant is no longer in possession of a fund, a plan cannot enforce an equitable lien), and *Bilyeu v. Morgan Stanley Long Term Disability Plan*, 683 F.3d 1083 (9th Cir. 2012) (same).

be applied first to reimburse the Plan in full for benefits advanced by the Plan . . . and without reduction for attorneys' fees, costs, expenses or damages claimed by the covered person." Participants must notify the plan and obtain its consent before settling claims.¹¹⁹

The Supreme Court reviewed the holdings of *Great-West*, *Sereboff*, and *McCutchen*, and then distinguished *Sereboff* and *McCutchen* from the situation in *Montanile* on the ground that the plaintiffs in *Sereboff* and *McCutchen* sought "specifically identifiable funds" that were within the plan participants' possession or control.¹²⁰ In contrast, the disputed funds in *Montanile* had been dissipated by the participant *before* the plan brought its subrogation enforcement claim.¹²¹ The Supreme Court found this fact dispositive because under principles of equity, "[a] defendant's expenditure of the entire identifiable fund on nontraceable items (like food or travel) destroys an equitable lien. The plaintiff then may have a personal claim against the defendant's general assets—but recovering out of those assets is a *legal* remedy, not an equitable one."¹²² According to the *Montanile* Court, equitable remedies "are, as a general rule, directed against some specific thing."¹²³ According to the Supreme Court, the participant's dissipation of the funds, even when done wrongfully to thwart enforcement of the equitable lien, does not create an exception to the rule that an equitable lien cannot be enforced against a defendant's general assets.¹²⁴ In other words, the participant *Montanile's* inequitable conduct successfully defeated the plan's claim for equitable relief.

The *Montanile* Court pointedly rejected the plan's policy-based arguments that, "unless plans can enforce reimbursement provisions against a defendant's general assets, plans will lack effective or cost-efficient remedies, and participants will dissipate any settlement as quickly as possible, before [plan] fiduciaries can sue."¹²⁵ In particular, the plan complained that "tracking and participating in legal proceedings is hard and costly" and "settlements are often shrouded in secrecy."¹²⁶ The Supreme Court offered three justifications for rejecting these policy arguments. The *Montanile* Court began by observing that "vague notions of a statute's 'basic purpose' are . . . inadequate to overcome the words of its text regarding the *specific* issue under consideration."¹²⁷ Next, the *Montanile* Court in-

119. *Montanile*, 136 S. Ct. at 655 (citations omitted).

120. *See id.* at 658.

121. *Id.*

122. *Id.*

123. *Id.* (quoting S. SYMONS, POMEROY'S EQUITY JURISPRUDENCE § 1234, at 694 (5th ed. 1941)).

124. *See id.* at 659.

125. *Id.* at 661.

126. *Id.* at 662.

127. *Id.* at 661.

vited Congress to address the problem, and even proposed how section 502(a)(3) might be amended:

Had Congress sought to prioritize the [plan]’s policy arguments, it could have drafted § 502(a)(3) to mirror ERISA provisions governing civil actions. One of those provisions, for instance, allows participants and beneficiaries to bring civil actions “to enforce [their] rights under the terms of the plan” and does not limit them to equitable relief.¹²⁸

Finally, the *Montanile* Court dismissed the plan’s practical policy argument that monitoring state court tort lawsuits, recoveries, and the distribution of funds was difficult and expensive, noting that the plan had been warned that the settlement funds would be distributed, but nevertheless waited “half a year” to bring its reimbursement claim.¹²⁹

C. The Plan Administrator’s Reaction to *McCutchen* and *Montanile*

In response to *McCutchen*, employers who sponsored self-insured group health plans amended the language of their plan reimbursement clauses.¹³⁰ The conventional wisdom became that plan reimbursement provisions should expressly provide for the plan to receive full reimbursement prior to the injured participant receiving any of the funds obtained from a third party, while clearly negating all equitable defenses such as the make whole rule, the common-fund doctrine, or any other equitable rule or doctrine that could reduce the plan’s first-dollar recovery.¹³¹ Today, a robust plan reimbursement clause would read like this:

Right of Reimbursement

The Plan, in its sole discretion, may conditionally advance payment of medical benefits in situations where an injury,

128. *Id.*

129. *See id.* at 662. Justice Ginsberg alone dissented from the majority opinion in *Montanile*. She found that permitting a participant to escape a contractual reimbursement obligation by spending settlement funds quickly on nontraceable items to be a “bizarre conclusion” attributable to the Supreme Court’s prior decision in *Great-West* and its progeny, which she viewed as erroneously interpreting the meaning of “appropriate equitable relief” under section 502(a)(3). *Id.* (Ginsburg, J., dissenting).

130. Pursuant to the settlor function doctrine, “[e]mployers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans.” *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995); *see* Colleen E. Medill, *Regulating ERISA Fiduciary Outsourcing*, 102 IOWA L. REV. 505, 522–24 & nn.107–121 (2017) (describing Supreme Court decisions creating the settlor function doctrine).

131. *E.g.*, John E. B. Gerth & Stanley E. Graham, *Slicing the Pie: Protecting Health Plan Subrogation Rights Post McCutchen*, 27 HEALTH L. 44, 46 (2014); Bart A. Karwath & Brian E. Casey, *Supreme Court: Health Plan Reimbursement Provisions Trump Equitable Doctrines*, RES GESTAE 10, 14 (Oct. 2013).

sickness, disease or disability is caused in whole or in part by, or results from, the acts or omissions of a third party. The Participant agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these reimburse provisions in their entirety. The Plan shall be entitled to recover 100% of the benefits paid, without any deduction or reduction for attorneys' fees and costs, and without application of the make-whole rule, the common-fund doctrine, equitable principles designed to prevent unjust enrichment, or any other similar legal or equitable theory or doctrine, without regard to whether the Participant is fully compensated by the Participant's recovery from all sources. This right of reimbursement shall bind the Participant's guardian, estate, executor, personal representative, and heir(s).

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan. Even if the Participant's recovery is less than the medical benefits paid by the Plan, the Plan is entitled to be paid all of the recovery achieved, without reduction for attorney's fees and costs.

By accepting medical benefits from the Plan, the Participant agrees the Plan shall have an equitable lien on any funds received by the Participant and/or the Participant's attorney from any source. The Plan's equitable lien shall supersede all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights that may interfere with or compromise in any way the Plan's equitable lien and right to reimbursement. The obligation of the Participant to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical care expenses.

The Participant agrees to request that the Plan's name be included as a co-payee on any and all checks made payable to Participant and/or the Participant's attorney. If the Participant fails to reimburse the Plan in accordance with these Plan provisions out of any judgment or settlement received, the Participant will be responsible for any and all expenses, including but not limited to attorney's fees and costs, associated

with the Plan's attempt to enforce these reimbursement provisions.¹³²

After *Montanile*, some self-insured group health plans added an internal "penalty" for the failure to reimburse the plan by providing that *future* benefits would be offset by the reimbursement amount owed to the plan. A typical offset penalty provision would read like this:

Offset of Benefits

If timely reimbursement is not made to the Plan, or if the Participant fails to comply with any of the requirements of the Plan regarding the Plan's right of reimbursement, the Plan has the right, in addition to any other lawful means of recovery, to offset payment of any future medical benefits under this Plan on behalf of the Participant in an amount equivalent to any outstanding amounts owed by the Participant to the Plan.¹³³

Armed with this type of reimbursement clause language, sophisticated plan administrators today engage in proactive measures to enforce the plan's right of reimbursement.¹³⁴ Post-*McCutchen* and *Montanile*, the law of ERISA subrogation claims creates significant problems for injured plan participants, the personal injury bar, employer-sponsored self-insured group health plans and their plan administrators, and federal and state courts. These problems, which are described in detail below in Part II, could be resolved (at least in part) by the targeted statutory amendment proposed in Part III of the Article.

III. POST-MCCUTCHEN AND MONTANILE PROBLEMS

A. Disincentives to Litigate Personal Injury Claims or Cooperate with Plan Administrators

As a result of *McCutchen*, injured participants with health care coverage through a self-insured group health plan are less likely to

132. This reimbursement provision is an exemplar based on the authors' review of plan document language from a variety of published and unpublished sources combined with original drafting.

133. This offset of future benefits provision is an exemplar based on the authors' review of various plan document language from a variety of published and unpublished sources combined with original drafting.

134. See Baron & Lamb, *supra* note 43, at 325 n.4 (quoting a spokesperson for the subrogation industry as stating that "There are certain employers who perhaps have a terminator attitude with regard to pursuing subrogation even in the light of some of the most atrocious circumstances.").

litigate personal injury claims. No participant wants to serve “as an unpaid collection agent for the plan,”¹³⁵ a result that is more likely if the plan requires first-dollar, full reimbursement of medical expenses paid without sharing in the costs to pursue litigation against a third party who caused the participant’s injuries.

The plaintiffs’ personal injury bar has reacted to *McCutchen* with a range of responses that have resulted in fewer personal injury actions being filed on behalf of participants in self-insured plans, and less cooperation with plan administrators if a case is filed. This range of responses, and the resulting adverse impacts, are summarized below.

1. Screen and Decline Borderline Cases

The facts of *McCutchen* perfectly illustrate the dilemma of the injured participant’s prospective lawyer, who usually must rely on a contingency fee set as a percentage of the total recovery as compensation for her legal services.¹³⁶ As a result of *McCutchen*, plaintiffs’ personal injury lawyers must screen potential cases and evaluate at a very early stage two critical factors: (1) the amount the prospective plaintiff’s health plan will require as reimbursement for medical expenses; and (2) the amount of insurance coverage and other assets held by the defendant. If the amount required as reimbursement by an employer’s self-insured health care plan makes it unlikely that the injured plan participant will net anything from the tort recovery, then the contingency fee lawyer has two options. One option, attempting to negotiate a lesser reimbursement amount with the participant’s self-insured plan, is discussed below. The other option is to simply decline to represent the injured plan participant.¹³⁷

By deferring to plan document language that rejects application of the common-fund doctrine in determining the amount of reimburse-

135. *US Airways, Inc. v. McCutchen*, 133 S. Ct. 1537, 1550 (2013).

136. The result in *McCutchen*, where the injured plan participant achieved a negative net recovery after reimbursement of the plan and the payment of his attorney’s fees and costs, is certainly possible, particularly for severely injured participants with large medical bills. For other examples, see Jonathan P. Connery, Note and Comment, *Personal Injury Victims As Insurance Collection Agents: ERISA Preemption of State Antisubrogation Laws*, 24 J.L. & POL’Y 131, 131–33 (2015) (describing the *Shank* and *Ridler* cases) and Baron & Lamb, *supra* note 44, at 326 n.5 (collecting cases where the amount of the reimbursement to the plan adversely impacted a severely injured plan participant).

137. See Karen Ertel, *Insurer May Take Share of Damages Award*, *Supreme Court Rules*, 42 TRIAL 92 (July 2006) (quoting an attorney as saying that personal injury lawyers “simply will walk away” from cases involving potentially large ERISA health plan claims for reimbursement as a result of the Supreme Court’s ruling in *Sereboff*); Karwath & Casey, *supra* note 131, at 14 (“If there will be little or nothing left for injured parties after paying the lawyers and reimbursing the health plan, injured parties will have little or no incentive to pursue claims against third parties”).

ment owed to the plan, *McCutchen* creates two negative effects. First, self-insured plans in general are likely to recoup less in reimbursements overall because injured plan participants and their attorneys, acting in a risk-adverse fashion under decision-making conditions of uncertainty, are more likely to decline cases that could result in some level of reimbursement for the plan.¹³⁸ From the perspective of the personal injury attorney who renders legal services on a contingency fee basis, the precise calculation of damages in a personal injury lawsuit can be challenging.¹³⁹ Moreover, the defendant's insurance coverage and other potential assets typically cannot be ascertained with certainty until the claim has been filed and the discovery process is underway. The calculation of the potential net recovery by the injured participant, however, must at least be estimated to be in the positive range before the attorney will undertake the representation.

The second negative effect of *McCutchen* falls on society as a whole. As the Seventh Circuit explained, the "prospect [that a plan will not have to pay its share of attorneys' fees] might well deter a suit likely to result in a judgment or settlement not much higher than the benefits available under the plan—and in that event the language on which the plan relies would produce undercompensation for harms that were unrelated to the type of harm to which benefits pertain."¹⁴⁰ When severe injuries are undercompensated due to artificial incentives, the burden of care and support ultimately may be borne by government-provided, taxpayer-financed social services.

2. Attempt to Pre-Negotiate a Set Reimbursement Amount

Prior to *McCutchen*, it was not uncommon for a plan administrator (or the plan's stop-loss insurer as the plan's assignee) to negotiate in advance of the commencement of personal injury litigation with the injured participant's lawyer regarding a reduction in the amount of the anticipated recovery that must be paid as reimbursement to the plan. This negotiated discount served as an indirect recognition that the plan would bear a share of the attorneys' fees and costs incurred in the personal injury litigation that produced the recovery by accepting

138. See Karwath & Casey, *supra* note 131, at 14 ("Reimbursements that might otherwise be obtained for health plans might be uncollected because the injured party has no incentive to obtain a recovery.").

139. See Kristin L. Huffaker, Note, *Where the Windfall Falls Short: "Appropriate Equitable Relief" After Sereboff v. Mid Atlantic Medical Services, Inc.*, 61 OKLA. L. REV. 233, 249 (2008) (explaining that courts have difficulty in calculating the economic value of damages for permanent disability, mental anguish, physical pain, loss of income, and future aspects of each of these components).

140. *Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Wells*, 213 F.3d 398, 402 (7th Cir. 2000).

less than full reimbursement.¹⁴¹ After *McCutchen*, with robust plan document language such as the exemplar presented in Part I.C of the Article, today there is much less incentive for the plan administrator to negotiate a reduced reimbursement amount.

ERISA fiduciary law, however, may in some circumstances compel the plan administrator to accept a discounted reimbursement as full payment. For example, assume that without a negotiated discount the plan will recover nothing at all for a very large medical bill because a claim for first-dollar, full reimbursement without cost-sharing of attorney's fees and litigation expenses renders the case economically infeasible on a contingency-fee basis. In this situation, a reduced recoupment for the plan in exchange for litigation cost-sharing would appear to be the more prudent choice for the plan administrator. It is at least arguable that if an attorney on behalf of an injured plan participant contacts the plan with an offer to negotiate litigation cost-sharing, the plan administrator has an affirmative fiduciary duty under ERISA's exclusive benefit rule and the duty of prudence to evaluate the offer in light of the potential net recovery of plan assets.¹⁴² If enforcement will result in a significant reimbursement to the plan, thereby increasing the pool of assets available to pay other participant claims for health care benefits, then the plan administrator may have a fiduciary duty to accept the offer.¹⁴³ In short, "a bird in the hand is worth two in the bush."¹⁴⁴

Negotiating a reduced reimbursement amount in disregard of the plan reimbursement clause language was considered to be a "matter of practice" among plan administrators prior to *McCutchen*.¹⁴⁵ For example, a plan administrator might choose to negotiate a reduced reimbursement claim amount in exchange for an agreement by the participant's attorney to limit the scope of the participant's document requests made to the plan administrator under ERISA section

141. See Gerth & Graham, *supra* note 131, at 46; Karwath & Casey, *supra* note 131, at 15.

142. See discussion *supra* text and notes 42–43.

143. See Karwath & Casey, *supra* note 131, at 14–15 ("Health plans . . . [may] have to decide whether they want to directly pursue (and fund) litigation against third parties or simply go without otherwise available reimbursements. For this reason, a health plan should be willing to reduce its reimbursement claim so that the injured person has greater incentives to pursue recovery from the third party.").

144. Ecclesiastes 6:9–11.

145. See Gerth & Graham, *supra* note 131, at 46 ("Many health plans as a matter of practice effectively follow the common fund doctrine by making a reduction to reimbursement claims to account for a pro rata portion of attorneys' fees, even in circumstances where the plan expressly disclaims any such requirement. The reasons for doing so run the gamut, from a sense that it is fair for the health plan to share in the cost of the recovery to the economic reality that negotiating for full reimbursement for every claim increases administrative expenses for plan administrators.").

104(b)(4)¹⁴⁶ as a way to reduce the administrative expenses associated with the litigation.¹⁴⁷

This “everything’s negotiable” approach is actually consistent with the plan administrator’s responsibility to execute his fiduciary duties of plan administration “in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of [ERISA].”¹⁴⁸ Section 404(a)(1)(D)’s underlying purpose is to provide an important check on potential employer overreaching under the settlor function doctrine by requiring that the plan administrator must *disregard* any terms of the plan that would be contrary to ERISA’s other statutory provisions.¹⁴⁹ In the context of reimbursement clause enforcement and related negotiations, the exclusive benefit rule and the fiduciary duty of prudence may require the plan administrator to disregard the plain language of the plan’s reimbursement clause.¹⁵⁰

3. *Ignore Reimbursement Demand Letters or Provide a Non-Binding Response*

Montanile obviously incentivizes injured plan participants to simply ignore reimbursement demand letters from the plan’s administrator. Due to the pre-existing relationship between the plan and the injured participant, however, the participant who accepts health care benefits from the plan will most likely be contractually bound to reimburse the plan (unless the recovered funds are dissipated, as in *Montanile*, before the plan administrator takes legal action). The exemplar of a plan reimbursement clause presented in section I.C. makes this legal right of reimbursement in exchange for plan benefits very clear.

Unlike the participant, the participant’s personal injury lawyer does not have a pre-existing relationship with the plan and is not bound by the terms of the plan’s reimbursement clause. For the participant’s attorney, the quandary becomes whether, and if so how, to respond to a reimbursement demand letter without contractually

146. 29 U.S.C. § 1024(b)(4) (2012).

147. See Gerth & Graham, *supra* note 131, at 46.

148. 29 U.S.C. § 1104(a)(1)(D) (2012).

149. See Medill, *supra* note 130, at 546 & n.235 (quoting Fifth Third Bancorp. v. Dudenhoeffer, 134 S. Ct. 2459, 2468 (“the duty of prudence *trumps the instructions of a plan document*”) (emphasis added)).

150. See discussion *supra* notes 44–47 and accompanying text. Of course, evaluating whether or not a positive net recovery of plan assets warrants disregarding the plan’s reimbursement clause language is a case-by-case determination that by definition lends itself to uncertainty. For this reason, our preferred approach would be a clear statutory rule that self-insured plans must cost-share in the tort recovery in lieu of a less certain case-by-case evaluation. See discussion *infra* section IV.A.

binding the attorney to later reimburse the plan if the participant fails to do so.

The facts of *Drury Industries, Inc. Health Care Plan and Trust v. Goding*¹⁵¹ provide a tutorial on how personal injury attorneys can respond, in a non-binding way, to a plan reimbursement letter. The plan participant, Sean Goding, was injured in a slip and fall accident and received \$11,423.79 in benefits from the plan. The participant later received compensation for his injuries in a tort settlement of a negligence claim. The plan attempted to secure reimbursement from the participant, but was unable to do so because the participant declared bankruptcy.¹⁵²

The plan then attempted to obtain reimbursement from the law firm that had represented the participant in the negligence action based on the following plan reimbursement clause language, coupled with the attorney's correspondence with the plan's administrator.

The Administrator, on behalf of the Employer, has first priority for the full amount of benefits they have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.

You and your legal representative must do whatever is necessary to enable the Administrator, on behalf of the Employer, to exercise their rights and do nothing to prejudice them.

...

To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Administrator's subrogation claim and any claim still held by you, the Administrator's subrogation claim shall be first satisfied before any part of Recovery is applied to your claim, your attorney fees, other expenses or costs.¹⁵³

During the attorney's representation of the Goding in the negligence action, the attorney had corresponded with the plan on two occasions. First, the attorney wrote to the plan administrator stating "[t]his will confirm that we do acknowledge [the plan]'s lien in this matter."¹⁵⁴ Several months later, the attorney wrote to the plan stating "we are not challenging your right to reimbursement/subrogation for payments made for the health care of Sean Goding relating [to] the injuries caused by his fall at the Hilton."¹⁵⁵ Based on these statements, the plan sued the attorney and his law firm in federal district court under ERISA section 502(a)(3), based on various equitable theo-

151. 692 F.3d 888 (8th Cir. 2012).

152. *Id.*

153. *Id.* at 891–92 (emphasis added).

154. *Id.* at 892.

155. *Id.*

ries including an equitable lien by agreement, restitution, and imposition of a constructive trust.¹⁵⁶

The district court granted a motion for summary judgment in favor of the defendants, and awarded attorney's fees to the attorney's law firm for its defense costs. The plan appealed both the grant of summary judgment and the attorney's fees award to the Eighth Circuit, which affirmed the district court's ruling on both issues.¹⁵⁷ In so doing, the Eighth Circuit's analysis provides clear guidance to the personal injury bar and plan administrators on what constitutes a binding reimbursement agreement between the plan and the injured participant's lawyer:

A subrogation agreement between a client and an ERISA plan is only enforceable against a client's attorney if the attorney agrees with a client and a plan to honor the plan's subrogation right.

In [*Hotel Employees & Restaurant Employees International Union Welfare Fund v.*] *Gentner*,¹⁵⁸ the Ninth Circuit reasoned that "[m]ere notice or knowledge of the subrogation agreement or lien does not constitute an implied contract between the attorney and the plan." In that case, the client . . . executed a subrogation agreement with the fund [His] attorney was aware of the subrogation agreement but did not sign or otherwise agree to it. The Ninth Circuit held that under these facts, the fund could not enforce the lien as an implied contract against the attorney.

Unlike in *Gentner*, the attorney in [*Southern Council of Industrial Workers v.*] *Ford*¹⁵⁹ not only knew about the subrogation agreement but also himself signed the subrogation agreement. In that case, before the client settled her personal injury claim with the plan administrator, both she and her attorney signed a subrogation agreement providing that they would reimburse the fund from the proceeds of any recovery received for the client's injuries. This was the key fact for our holding in that case. Citing *Gentner*, we determined that [b]ecause [the attorney] himself signed the subrogation agreement, . . . the complaint also stated an ERISA claim against him for violation of the subrogation clause.

Here, [the plan] argues that [the participant's attorney] should be bound by the subrogation agreement on the basis of two letters . . . sent to [the plan administrator]. . . . [The statements in the two letters] clearly acknowledge the validity and existence of a subrogation agreement between [the participant] and [the plan]. However, absent from these statements or any other communication identified by [the plan] is a promise by [the participant's attorney] to take any action to himself enforce the subrogation agreement or even to ensure that [the participant] abide by it.

Without such a promise, the acknowledgment alone is insufficient to establish an implied contract. . . . Although [the participant's attorney] acknowledged the existence of the lien against the settlement . . . , [the attorney] never

156. *See id.*

157. *See id.*

158. 50 F.3d 719 (9th Cir. 1995).

159. 83 F.3d 966 (8th Cir. 1996).

agreed with [the plan] and [the participant] to honor the [p]lan's subrogation right. Because [the participant's attorney] was not a party to the subrogation agreement, [the plan] cannot enforce that agreement against [the participant's attorney].¹⁶⁰

4. *Distribute and Dissipate the Recovered Funds to Avoid an Equitable Lien*

Montanile clearly encourages plan participants to quickly spend any amounts recovered as compensation in a personal injury action on nontraceable assets.¹⁶¹ If a participant ignores the plan's demand letter, collects on a personal injury claim, and then quickly spends the recovered funds, if the plan document so provides the plan administrator can offset the payment of future plan benefits.¹⁶² But if the injured participant does not intend to return to work, this benefit offset "penalty" will not be an effective deterrent to a participant who wants to "take the money and run."¹⁶³

B. Obstacles to Reimbursement Clause Enforcement

As frustrating as ERISA subrogation claims may be for injured plan participants and the plaintiffs' personal injury bar, the status quo is equally, if not more, frustrating for plan administrators. As explained below, the current system presents numerous practical and procedural obstacles to the efficient enforcement of plan reimbursement clauses for employer self-insured plans. The required monitoring of personal injury claims brought by plan participants primarily in the state courts, coupled with exclusively federal subject matter jurisdiction over the plan's reimbursement claim, result in both higher plan administrative costs and a waste of state and federal judicial resources due to bifurcated state court/federal court adjudications.

1. *Heightened Monitoring (the "letter writing campaign")*

After *Montanile*, plan administrators must closely monitor potential tort litigation and related disbursements of funds to injured plan participants.¹⁶⁴ Although this point is self-evident, in practice such monitoring is cumbersome, difficult, and costly for the plan.¹⁶⁵ Even though a "letter writing campaign" by itself cannot avoid distribution

160. *Drury Indus.*, 692 F.3d at 894–95 (internal quotations and citations omitted).

161. See discussion *supra* subsection II.B.4.

162. For an illustration, see the offset of benefits exemplar presented in section II.C.

163. See Noah Lipschultz, *Go On, Take the Money and Run—Supreme Court Limits ERISA Plans' Reimbursement Rights*, 24 ERISA LITIG. REP., Issue 1, *1 (Feb. 2016) (quoting STEVE MILLER BAND, *Take the Money and Run*, on FLY LIKE AN EAGLE (Capitol Records 1976)).

164. See discussion *infra* subsection III.B.1.

165. See Lipschultz, *supra* note 163, at *3 (criticizing the *Montanile* Court's "startlingly naïve" assumption that it is easy for plans to prevent dissipation of settle-

and dissipation of the recovered funds by the participant (or bind a savvy personal injury attorney), it is required by the plan administrator's fiduciary duties.¹⁶⁶ As explained below, the plan administrator may attempt to take the most direct route to securing reimbursement by intervening in the state court tort action, but the outcome of this approach is uncertain due to the exclusively federal nature of claims to enforce a plan reimbursement clause.¹⁶⁷ The plan administrator may be able to seek to obtain injunctive or declaratory relief in federal court to control the disbursement of funds in the underlying state court action, but again, the law in this area is murky.¹⁶⁸ This leaves the plan administrator with one certain (but expensive) option, namely to sue the participant (and possibly her personal injury attorney) in federal district court by asserting a claim for injunctive or equitable relief under ERISA section 502(a)(3).¹⁶⁹

2. *Intervention in the Participant's State Court Tort Action*

The possibility of intervention in the participant's state court tort action was raised, but not addressed, in *Great-West*. In part due to the odd procedural posture of the case, the majority opinion noted that "[w]e express no opinion as to whether petitioners could have intervened in the state-court tort action brought by respondents or whether a direct action by petitioners against respondents asserting state-law claims such as breach of contract would have been pre-empted by ERISA."¹⁷⁰ Since *Great-West* was decided, at least one legal scholar has argued that any state law-based attempt to enforce an ERISA plan reimbursement clause in state court is preempted by ERISA.¹⁷¹

The state courts have ruled both for and against attempts at intervention by plan administrators.¹⁷² The outcomes of these state court cases, which predate *Sereboff*, appear to turn on how both the participant's claim in the state court action, and the attempted intervention

ment funds through monitoring and will not pose hardship or additional costs on plans).

166. See discussion *supra* notes 44–47 and accompanying text.

167. See discussion *infra* subsection III.B.2.

168. See discussion *infra* subsection III.B.3.

169. See discussion *infra* subsection III.B.4.

170. *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 220 (2002).

171. See E. Farish Percy, *Applying the Common Fund Doctrine to an ERISA-Governed Employee Benefit Plan's Claim for Subrogation or Reimbursement*, 61 FLA. L. REV. 55, 72 (2009) ("state-law claims for subrogation or reimbursement are pre-empted regardless of whether the plan fiduciary initiates a direct civil action against the plan participant or third-party tortfeasor, or moves to intervene in the plan participant's tort case. Given that the plan fiduciary's ability to intervene on behalf of the plan is based on plan subrogation and reimbursement provisions, such intervention 'relates to' an employee benefit plan in exactly the same way a direct claim for reimbursement or subrogation does.").

172. See discussion *infra* notes 179–84 and accompanying text.

by the plan administrator, are characterized by the state court. If the attempted intervention is characterized as an attempt by the plan administrator to enforce the terms of the reimbursement clause under ERISA section 502(a)(3),¹⁷³ then intervention will not be allowed due to a lack of subject matter jurisdiction by the state court.¹⁷⁴ The Louisiana Supreme Court's reasoning in *A. Copeland Enterprises, Inc., v. Slidell Memorial Hospital*,¹⁷⁵ described below, reflects this approach. If, however, the attempted intervention is characterized as related to a claim by the participant "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan" under ERISA section 502(a)(1)(B),¹⁷⁶ then the state courts have concurrent subject matter jurisdiction,¹⁷⁷ and the attempted intervention may be successful. The Mississippi Supreme Court's analysis in *Yerby v. United Healthcare Insurance Co.*,¹⁷⁸ described after *Copeland Enterprises*, illustrates this type of reasoning.

In *Copeland Enterprises*, the plan administrator intervened in a state district court medical malpractice action against the participant's health care providers seeking reimbursement of \$731,602.57 in medical expenses paid by the plan on the participant's behalf.¹⁷⁹ The Louisiana Supreme Court ultimately ruled that the state district court erred in granting the motion to intervene because the state district court lacked subject matter jurisdiction to determine the merits of the plan administrator's subrogation claim:

Congress specifically bestowed upon state courts concurrent jurisdiction in matters arising under [ERISA § 502(a)(1)(B)] That being the case, we, construing [ERISA § 502] narrowly, interpret this section to mean that a PARTICIPANT or a BENEFICIARY may bring an action in either state or federal court to 1) recover benefits due to him; 2) enforce his rights; and 3) clarify his rights to future benefits, under the terms of the plan Here, Copeland is neither the proper party (a participant [or a]beneficiary . . .) to bring an action in this Court under ERISA, nor is this action one that falls within the scope of this Court's concurrent jurisdiction. Copeland is the fiduciary seeking to enforce a subrogation right under the terms of its employee benefit plan. It is apparent that this action is not within the realm of this Court's concurrent jurisdiction as enumerated by [ERISA]. Thus, based upon the clear wording of section [502], the federal district court would have exclusive subject matter jurisdiction to determine whether Copeland is entitled to reimbursement pursuant to a subrogation agreement.¹⁸⁰

173. 29 U.S.C. § 1132(a)(3) (2012).

174. § 1132(e)(1).

175. 657 So. 2d 1292 (La. 1995).

176. § 1132(a)(1)(b).

177. § 1132(e)(1).

178. 846 So. 2d 179, 186–87 (Miss. 2002).

179. See *Copeland Enters.*, 657 So. 2d at 1294–95.

180. *Id.* at 1302; see also *Jefferson-Pilot Life Ins. Co. v. Krafka*, 57 Cal. Rptr. 2d 723, 726–27 (Cal. Ct. App. 1996) (quoting *Copeland Enters.*, 657 So. 2d at 1302). The Kansas Supreme Court subsequently relied on *Copeland Enterprises* to dismiss a

In contrast, the Mississippi Supreme Court in *Yerby v. United Healthcare Insurance Co.*¹⁸¹ permitted the plan's designated subrogation collection agent to intervene in a state tort action filed by a plan participant who had been injured in an automobile accident. The collection agent claimed that that the plan was contractually entitled to recover any benefits paid or payable for medical treatment of the participant out of any tort recovery.¹⁸² The Mississippi Supreme Court agreed, reasoning as follows:

The case at hand presents the very issue that the Supreme Court refrained from deciding [in *Great-West*] ("We express no opinion as to whether petitioners could have intervened in the state-court tort action brought by respondents . . ."). Yerby denies that United, as an intervening fiduciary, is able to seek relief on a claim that it could not have initiated itself under § [502](a)(1)(B) (only "participant or beneficiary" may bring action) . . . [T]he inability of United to have initiated suit under § [502](a)(1)(B) in no way barred it from intervening of right under [Mississippi Civil Procedure] Rule 24(a)(2).

Further, while the Supreme Court stated that cases under § [502](a)(3) may only provide equitable relief, it specifically noted that the same requirement is not mandated in § [502](a)(1)(B), which both parties agree is the section at issue in this case. *Knudson*, 122 S. Ct. at 718. ("In the very same section of ERISA as § 502(a)(3), Congress authorized 'a participant or beneficiary' to bring a civil action 'to enforce his rights under the terms of the plan,' without reference to whether the relief sought is legal or equitable."). Thus, under § [502](a)(1)(B), when determining what rights a Plan participant has in a recovery, any and all relief available is appropriate. Clearly, in the present case, Yerby is a Plan beneficiary and United is the Plan fiduciary. Under ERISA, § [502](a)(3) will not allow for United to bring suit in a federal court and obtain anything other than equitable relief. The Supreme Court, however, expressly left open the question of whether a Plan fiduciary (United) may receive other forms of relief when a Plan beneficiary (Yerby) brings suit under § [502](a)(1)(B) to enforce or clarify his or her rights under the Plan. To write in a restriction on the type of relief available under § [502](a)(1)(B), which is exactly what would occur if this Court agreed with Yerby, would be an "attempt to adjust the 'carefully crafted and detailed enforcement scheme' embodied in the text that Congress has adopted." If the Supreme Court of the United States refuses to do this, it is not the place of this Court to do so. Thus, Yerby's argument that only equitable relief is available is unfounded."¹⁸³

Copeland Enterprises and *Yerby* represent the most clearly reasoned opinions among a mere handful of older state court decisions involving intervention by a plan administrator.¹⁸⁴ Although the plan

claim, filed in state court, by a plan administrator seeking to enforce the plan's right of reimbursement against a plan participant. See *Funk Mfg. Co., v. Franklin*, 927 P.2d 944, 949 (Kan. 1996).

181. 846 So. 2d 179 (Miss. 2002).

182. *Id.* at 180.

183. *Id.* at 186–87.

184. See, e.g., *Jefferson-Pilot Life Ins. Co.*, 57 Cal. Rptr. 2d 723; *Faires v. Pageau*, No. CV 970403163S, 1999 WL 1001164 (Conn. Super. Ct. Oct. 26, 1999); *Funk Mfg. Co.*, 927 P.2d 944.

in *Yerby* successfully opted to intervene in the participant's state court tort action, most plan administrators would prefer to litigate in federal court, before federal district court judges who are familiar with ERISA civil remedies and the Supreme Court's precedents regarding plan benefit claims under section 502(a)(1)(B) and ERISA subrogation claims under section 502(a)(3).

3. *Injunctive or Declaratory Relief in Federal Court*

In lieu of intervening directly in the participant's state court action, the plan administrator may seek injunctive or declaratory relief in federal court regarding disbursement of the recovered funds in the state court tort action. The Federal Anti-Injunction Act (AIA)¹⁸⁵ comes into play if the plan administrator takes this indirect approach. The AIA provides, "a court of the United States may not grant an injunction to stay proceedings in a State court except as expressly authorized by an Act of Congress, or where necessary in aid of its jurisdiction, or to protect or effectuate its judgments."¹⁸⁶ There are two bodies of law that have developed under the AIA, one dealing with actions seeking to enjoin a state court, the other dealing with actions seeking a declaratory judgment that impacts a pending state court action.

Injunctive Relief

Although the AIA generally prohibits the federal courts from issuing injunctions to stay proceedings in state courts, the statute provides for three exceptions to this general rule.¹⁸⁷ For purposes of ERISA subrogation claims, the relevant exception is for injunctions that are "expressly authorized" by federal statute.¹⁸⁸ The test for whether a federal statute expressly authorizes an injunction, as first elaborated by the Supreme Court in *Mitchum v. Foster*,¹⁸⁹ is whether the statute, "clearly creating a federal right or remedy enforceable in a federal court of equity, could be given its intended scope only by the stay of a state court proceeding."¹⁹⁰ If so, then an injunction is "ex-

185. 28 U.S.C. § 2283 (2012).

186. *Id.*

187. *See Atl. Coast Line R.R. Co. v. Bhd. of Locomotive Eng'rs*, 398 U.S. 281, 286 (1970).

188. § 2283 (excepting injunctions: (1) expressly authorized by statute; (2) necessary to aid the court's jurisdiction; or (3) required to protect or effectuate the court's judgments); *see Denny's, Inc. v. Cake*, 364 F.3d 521, 529 (4th Cir. 2004); *see also* *Chick Kam Choo v. Exxon Corp.*, 486 U.S. 140, 145–46 (1988) (quoting 28 U.S.C. § 2283); *Atl. Coast Line R.R. Co.*, 398 U.S. at 287–88 (quoting 28 U.S.C. § 2283).

189. 407 U.S. 225 (1972).

190. *Id.* at 238 (finding that 42 U.S.C. § 1983 is the type of statutory scheme creating a unique federal right or remedy that could be frustrated if the federal courts were not permitted to enjoin state court proceedings).

pressly authorized” by the statute. Currently, the federal courts of appeals are divided over whether injunctive relief related to an ERISA subrogation claim is “expressly authorized” under the *Mitchum v. Foster* standard.¹⁹¹

The Second and Sixth Circuits hold that an injunction directed at the distribution of a recovery from a state court tort action to preserve the plan’s right to reimbursement is expressly authorized by ERISA.¹⁹² As the Sixth Circuit explained in *General Motors Corp. v. Buha*, “[i]t is central to the statutory scheme that ERISA not be subject to state and local laws which might frustrate its goals.”¹⁹³ Therefore, the court held:

ERISA meets both prongs of the *Mitchum* test. When a district court finds that an action in a state court will have the effect of making it impossible for a . . . plan to carry out its responsibilities under ERISA, the [Anti-Injunction Act does] not prohibit it from enjoining the state court proceedings.¹⁹⁴

In contrast, the Third, Fourth, Fifth, and Seventh Circuits hold ERISA does not expressly authorize injunctions of state court proceedings. As a result, in these jurisdictions the AIA will bar an attempt by the plan administrator to enjoin the distribution of a recovery from a state court tort action to preserve the plan’s right to reimburse-

191. *Compare* *Gilbert v. Burlington Indus., Inc.*, 765 F.2d 320, 329 (2d Cir. 1985) (holding fiduciary with respect to the plan is authorized under ERISA to seek an injunction of the state proceedings), *and* *Gen. Motors Corp. v. Buha*, 623 F.2d 455, 459 (6th Cir. 1980) (holding the injunction of state court proceedings is not barred by the Anti-Injunction Act because the state court action would make it impossible for fiduciary to carry out its responsibilities under ERISA), *with* *Trs. of Carpenters’ Health & Welfare v. Darr*, 694 F.3d 803, 807–08 (7th Cir. 2012) (holding ERISA § 502(a)(3)(A) does not expressly authorize injunctions against state courts), *Emp’rs Res. Mgmt. Co. v. Shannon*, 65 F.3d 1126, 1132 (4th Cir. 1995) (ruling ERISA does not fall within the expressly authorized exception to the Anti-Injunction Act), *1975 Salaried Ret. Plan for Eligible Emps. of Crucible, Inc. v. Nobers*, 968 F.2d 401, 410 (3d Cir. 1992) (holding ERISA does not expressly authorize “injunctions of state court actions simply because they are preempted by ERISA”), *Total Plan Servs., Inc. v. Texas Retailers Ass’n, Inc.*, 925 F.2d 142, 144–46 (5th Cir. 1991) (holding ERISA does not fall within the “expressly authorized” exception to the Anti-Injunction Act), *and* *U.S. Steel Corp. Plan for Emp. Ins. Benefits v. Musisko*, 885 F.2d 1170, 1178 (3d Cir. 1989) (holding ERISA does not expressly authorize an injunction of preempted state proceedings).

192. *Gilbert*, 765 F.2d at 329; *Buha*, 623 F.2d at 459.

193. *Buha*, 623 F.2d at 459.

194. *Id.*

ment.¹⁹⁵ The Third Circuit's reasoning in *United States Steel Corp. Plan for Employee Insurance Benefits v. Musisko*¹⁹⁶ is typical:

[n]owhere in the comprehensive legislative record [of ERISA] is there any indication that Congress intended to authorize injunctions against state courts. Indeed, the very act of delegating concurrent jurisdiction to the state courts for resolution of beneficiaries' claims is evidence of Congress' satisfaction that state tribunals would fairly and competently adjudicate such cases.¹⁹⁷

The *Musisko* court further reasoned that a federal court is not permitted to enjoin state court proceedings just because the state proceedings "invade an area pre-empted by federal law even when the interference is unmistakably clear The fact that the state proceeding presents a preemption issue does not alter the respect due the state tribunal. '[T]he proper course is to seek resolution of that issue by the state court.'"¹⁹⁸

The line of reasoning illustrated by *Musisko* is fundamentally flawed in two respects. First, Congress's decision to grant the federal district courts *exclusive* subject matter jurisdiction over claims to enforce the terms of a plan under ERISA section 502(e)(1)¹⁹⁹ strongly indicates that Congress did *not* intend for state tribunals to decide ERISA subrogation claims. Second, because state courts lack subject matter jurisdiction to hear a plan administrator's claim under ERISA section 502(a)(3) to enforce the terms of the plan's reimbursement clause, it may be futile to "seek resolution of that issue" by attempting to intervene in the state court action.²⁰⁰ Unless the state court is willing to characterize the participant's claim in the state court tort action as one to determine plan benefits under ERISA section 502(a)(1)(B) (the analysis adopted by the Mississippi Supreme Court in *Yerby*²⁰¹), it is simply impossible for the ERISA subrogation issue to be resolved by the state court.²⁰²

The Seventh Circuit in *Trustees of the Carpenters' Health & Welfare Trust Fund of St. Louis v. Darr*,²⁰³ while holding as a general rule that ERISA does not expressly authorize injunctive relief as an excep-

195. *Darr*, 694 F.3d at 807–08; *Shannon*, 65 F.3d at 1132; *Total Plan Servs., Inc.*, 925 F.2d at 144–46; *Musisko*, 885 F.2d at 1178; *see also Nobers*, 968 F.2d at 410 (following *Musisko*); *Int'l Union of Operating Eng'rs Local 399 v. Walsh, Knippen, Pollock & Cetina, Chartered*, No. 15 C 7143, 2015 WL 7077334 (N.D. Ill. Nov. 13, 2015) (following *Darr*).

196. 885 F.2d 1170.

197. *Id.* at 1177.

198. *Id.* at 1177–78 (quoting *Chick Kam Choo v. Exxon Corp.*, 486 U.S. 140, 149–50 (1988)) (internal citations omitted).

199. *See* 29 U.S.C. § 1132(e)(1) (2012).

200. *See* discussion *supra* notes 179–84 and accompanying text.

201. *See* discussion *supra* notes 178–80 and accompanying text.

202. *See* § 1132(e)(1) (granting the federal district courts exclusive subject matter jurisdiction over section 502(a)(3) claims).

203. 694 F.3d 803 (7th Cir. 2012).

tion to the AIA,²⁰⁴ appeared to at least recognize this problem of exclusively federal subject matter jurisdiction. The *Darr* Court posited that ERISA may expressly authorize an injunction against a state court if the state court lawsuit “will have the effect of making it impossible for a fiduciary of a[n ERISA] plan to carry out its responsibilities under ERISA.”²⁰⁵ The “impossible responsibility” in the ERISA subrogation claim context is collecting reimbursement, as required by the terms of the plan, from a participant who has every incentive after *Montanile* to thwart repayment by spending the funds.

Declaratory Judgments

In jurisdictions where the federal courts refuse to apply the “expressly authorized” exception for injunctive relief, the plan administrator may attempt to bring a declaratory judgment action in federal court as a means of effectively dictating the distribution of the recovered funds in the participant’s state court tort action. As a general rule, the federal courts have taken the view outside of the ERISA context that where the AIA bars an injunction, it also bars declaratory judgments that would have the same effect as an injunction.²⁰⁶ This interpretation is consistent with the Supreme Court’s reasoning in *Samuels v. Mackell*.²⁰⁷ In *Samuels*, the criminal defendants sought an injunction and a declaratory judgment in federal court against their state criminal prosecutions.²⁰⁸ Although not explicitly discussing the AIA, the Supreme Court stated:

[T]he propriety of declaratory and injunctive relief should be judged by essentially the same standards. In both situations deeply rooted and long-settled principles of equity have narrowly restricted the scope for federal intervention, and ordinarily a declaratory judgment will result in precisely the same interference with and disruption of state proceedings that the longstanding policy limiting injunctions was designed to avoid.²⁰⁹

Based on this reasoning, the *Samuels* Court concluded that where an injunction is impermissible, declaratory relief should be barred as

204. *See id.* at 807–08.

205. *Id.* at 808 (quoting *Emp’rs Res. Mgmt. Co. v. Shannon*, 65 F.3d 1126, 1132 (4th Cir. 1995)) (emphasis omitted). Although the state court lawsuit in *Darr* would have required the plan to pay a portion of an attorney’s fees in violation of plan terms, the Seventh Circuit concluded that the plan administrator could still carry out its duties under ERISA. *See id.*

206. *See Cheyenne & Arapaho Tribes v. First Bank & Trust Co.*, 560 Fed. Appx. 699, 707 n.8 (10th Cir. 2014); *Texas Emp’rs’ Ins. Ass’n v. Jackson*, 862 F.2d 491, 506 (5th Cir. 1988); *Ahrensfield v. Stephens*, 528 F.2d 193, 195 n.3 (7th Cir. 1975); *see also Samuels v. Mackell*, 401 U.S. 66, 72 (1971) (discussing how declaratory relief would have virtually the same impact as an injunction).

207. 401 U.S. 66 (1971).

208. *Id.* at 68.

209. *Id.* at 72.

well.²¹⁰ Despite *Samuels*, the law in the lower courts is far less clear, and no federal appellate court appears to have addressed the issue of whether a declaratory judgment in federal district court can be used as an alternative to seeking injunctive relief in those jurisdictions that do not recognize an ERISA subrogation claim as an exception to the AIA.

The Fourth Circuit's decision in *Denny's Inc. v. Cake*²¹¹ illustrates how some circuits have approached the declaratory judgment-in-lieu-of-an injunction issue. In *Denny's*, the Fourth Circuit relied on *Samuels v. Mackell* and held the Anti-Injunction Act bars the plan administrator from asserting a declaratory judgment claim if it would have the same effect as an injunction.²¹² The employer in *Denny's* had sought both a declaratory judgment, requesting the court to declare that ERISA preempted state law claims that its vacation pay plan violated South Carolina state law, and an injunction, seeking to enjoin the application of state law to the employer's vacation pay plan.²¹³ The Fourth Circuit determined that the employer's request for a declaratory judgment had the same effect as its request for an injunction.²¹⁴ Consequently, the Fourth Circuit ordered the complaint filed by the employer in federal district court to be dismissed on the ground that the AIA barred both requests for an injunction and declaratory relief.²¹⁵

In contrast, the Eighth Circuit in *Prudential Life Insurance Co. of America v. Doe*²¹⁶ held the AIA did not bar declaratory relief sought in federal court by an insurance company, who sought to limit the

210. *Id.* Although the Supreme Court limited its holding to cases where the state criminal prosecution had begun prior to the federal suit, other federal courts cite *Samuels* as support for barring a declaratory judgment action under the Anti-Injunction Act.

211. 364 F.3d 521 (4th Cir. 2004).

212. *See id.* at 528 n.8. (quoting *Texas Emp'rs' Ins. Ass'n v. Jackson*, 862 F.2d 491, 506 (5th Cir. 1988)). This principle that a party cannot use a declaratory judgment as an end-run around the Anti-Injunction Act is consistent with other areas of procedure. For instance, in *International Association of Entrepreneurs of America v. Angoff*, 58 F.3d 1266 (8th Cir. 1995), the defendant was untimely in attempting to remove a state court action and then subsequently brought a declaratory judgment action in federal court. *Id.* at 1268. The Eighth Circuit held that a declaratory judgment should not be used to circumvent the deadlines imposed by the removal statute or as a "convenient and temporally unlimited back door into federal court." *Id.* at 1270.

213. *Denny's*, 364 F.3d at 523.

214. *Id.* at 528 n.8 (quoting *Jackson*, 862 F.2d at 506).

215. *Denny's*, 364 F.3d at 531; *see also* *Emp'rs Res. Mgmt. Co. v. Shannon*, 65 F.3d 1126, 1134 (4th Cir. 1995) (holding the Anti-Injunction Act barred both declaratory and injunctive relief); *U.S. Steel Corp. Plan for Emp. Ins. Benefits v. Musisko*, 885 F.2d 1170, 1180 (3d Cir. 1989) (holding the district court erred in granting an injunction and a declaratory judgment because both were barred by the Anti-Injunction Act).

216. 140 F.3d 785 (8th Cir. 1998) ("*Doe II*").

mental health benefits available under one of its insured group health plans.²¹⁷ In *Prudential Life*, the insurance company, acting in its capacity as the plan's administrator, first filed a declaratory judgment action in federal court regarding the mental health benefits due to the participant under the terms of the plan.²¹⁸ The participant then filed an action against the insurance company in Illinois state court alleging numerous state law claims.²¹⁹ After the participant filed the state court action, the insurance company filed a second amended and restated complaint in federal court seeking a declaratory judgment that the participant's claims in state court were preempted by ERISA and were mandatory counterclaims in the employer's federal district court action.²²⁰ Based on these procedural facts, the Eighth Circuit held the AIA did not bar the insurance company's claim for declaratory relief.²²¹ In reaching this holding, the Eighth Circuit found it significant that the insurance company, who filed the ERISA-based claim for declaratory relief in federal district court, was the first litigant to file suit,²²² and further noted that the federal district court had discretion to determine whether to hear the declaratory judgment action.²²³

To summarize, the law (and thus the potential result) is simply uncertain if a plan administrator seeks injunctive or declaratory relief in federal court to control the disbursement of the funds in the state court tort action. Certainly, this technique may be an option for a plan administrator in select jurisdictions. But from a policy perspective, litigating over subject matter jurisdictional issues under the Anti-Injunction Act as an end-around for the Supreme Court's decision in *Montanile* seems unnecessarily complex and wasteful. As the above discussion makes clear, all of the players who are involved in ERISA subrogation litigation—plan participants and their tort lawyers, plan administrators, and the federal and state courts—are ill-served by the procedural complexity and uncertainty of the status quo.

4. *Equitable Relief in Federal Court Under Section 502(a)(3)*

The final option for the plan administrator who desires to enforce the terms of a self-insured plan's reimbursement clause is to file an ERISA subrogation claim in federal district court under section 502(a)(3). After four Supreme Court decisions, at least the federal

217. *Id.* at 787.

218. *Id.*

219. *Id.*

220. *Id.*

221. *Id.* at 788.

222. *Id.* at 788–89.

223. *See id.*; *see also* *NSG Am., Inc. v. Jefferson*, 218 F.3d 519, 523 (6th Cir. 2000) (citing *Prudential Ins. Co. of Am. v. Doe*, 76 F.3d 206, 210 (8th Cir. 1996) (“*Doe I*”) and *Doe II*, 140 F.3d at 789, as examples of courts taking the abstention route to thwart procedural fencing in the ERISA context).

common law governing ERISA subrogation claims filed in federal court is fairly clear.²²⁴ But to prevent the participant from dissipating the funds recovered through state court tort litigation after *Montanile*, the plan administrator must closely monitor the state court proceedings, while simultaneously pursuing the plan's reimbursement claim in federal district court. This system of bifurcated litigation is simply wasteful for both the plan administrator and the state and federal judiciary.

C. Conclusion: An Arbitrary and Inefficient Enforcement System

It is difficult to imagine that Congress intentionally created the current system for plan reimbursement claims as part of a "carefully crafted and detailed enforcement scheme."²²⁵ The law of ERISA subrogation claims has evolved over time through the process of federal common law.²²⁶ Unfortunately, the result today is an arbitrary and inefficient enforcement system for all of the interested stakeholders. The current law of ERISA subrogation claims: (1) makes it more difficult for injured plan participants to obtain legal services on a contingency fee basis; (2) requires the plaintiffs' personal injury bar to decline potentially meritorious cases or to avoid cooperation with the client's health care plan; (3) forces plan administrators to spend time and plan assets navigating a virtual legal labyrinth in fulfillment of their ERISA fiduciary duties; (4) increases the costs of voluntary plan sponsorship for employers; and (5) wastes valuable state and federal judicial resources by bifurcating litigation into a state court tort action and a federal court ERISA subrogation claim.

Although Congress's most recent attempt to repeal the employer mandate under the Affordable Care Act was not successful,²²⁷ the need for reform in this highly technical, yet highly important, area of the law remains. As the costs of sponsoring a group health plan continue to rise, employers become increasingly incentivized to not offer health insurance coverage to their workers and simply pay the tax penalty imposed by the employer mandate. Given the significant percentage of the workforce that obtains health insurance coverage through an employer's self-insured group health plan,²²⁸ national health care policy should emphasize reforms that minimize, to the extent possible, the costs to employers of voluntarily sponsoring and ad-

224. See discussion *supra* section II.B.

225. *Great-West Life & Ann. Ins. Co. v. Knudson*, 534 U.S. 204, 209 (2002) (quoting *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 254 (1993) (quoting *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146–47 (1985))).

226. See discussion *supra* section II.B.

227. See discussion *supra* notes 21–22 and accompanying text.

228. See discussion *supra* note 2 and accompanying text.

ministering group health plans. By enacting the targeted statutory amendment proposed in Part IV of the Article, Congress can resolve (or at least mitigate) the problems with the current enforcement system for plan reimbursement clauses, and thereby lend support to employers who voluntarily sponsor self-insured group health plans.

IV. A TARGETED STATUTORY AMENDMENT SOLUTION

Numerous scholars over the years have criticized the law of ERISA subrogation claims.²²⁹ Employers who sponsor self-insured health care plans and insurance industry representatives who provide plan administrative services for self-insured plans have argued in books, articles, and Supreme Court amicus briefs that strict enforcement of reimbursement clauses is necessary to contain the costs of the sponsoring the health care plan for the employer.²³⁰ Assuming one accepts the premise that recoupments from ERISA subrogation litigation re-

229. See Scott M. Aronson, *ERISA's Equitable Illusion: The Unjust Justice of Section 502(a)(3)*, 9 EMP. RTS. & EMP. POL'Y J. 247 (2005); Baron & Lamb, *supra* note 43; Connery, *supra* note 136; Ertel, *supra* note 137; Gerth & Graham, *supra* note 131; Huffaker, *supra* note 139; David M. Kono, *Unraveling the Lining of ERISA Health Insurer Pockets—A Vote for National Federal Common Law Adoption of the Make Whole Doctrine*, 2000 B.Y.U. L. REV. 427 (2000); Lipschultz, *supra* note 163; Brendan S. Maher, *The Affordable Care Act, Remedy, and Litigation Reform*, 63 AM. U. L. REV. 649 (2014); Brendan S. Maher & Radha A. Pathak, *Understanding and Problematizing Contractual Tort Subrogation*, 40 LOY. U. CHI. L. J. 49 (2008); Percy, *supra* note 171; Dennis J. Wiley, *Enforcing Recoupment Provisions After Great-West Life & Annuity Insurance Company v. Knudson: A Suggested Method of Analysis for Reviewing Courts*, 9 DEPAUL J. HEALTH CARE L. 1195 (2006).

230. Brief for Respondent at 46, *Montanile v. Bd. of Trs. of the Nat'l Elevator Indus. Health Benefit Plan*, 136 S. Ct. 651 (2016) (No. 14-723); Brief of Amici Curiae IBEW-NECA Southwestern Health & Benefit Fund and the Chamber of Commerce of the U.S.A. Supporting Respondent at 7, *Montanile*, 136 S. Ct. 651 (No. 14-723); Reply Brief for Petitioner at 22, *U.S. Airways, Inc. v. McCutchen*, 133 S. Ct. 1537 (2013) (No. 11-1285); Brief of Amici Curiae the Blue Cross Blue Shield Association and the Rawlings Company, LLC in Support of Petitioner at 7, *McCutchen*, 133 S. Ct. 1537 (No. 11-1285); Brief Amici Curiae for the National Association of Subrogation Professionals and the Self Insurance Institute of America, Inc. in Support of Petitioner at 23, *McCutchen*, 133 S. Ct. 1537 (No. 11-1285); Brief Amici Curiae for the Society for Human Resource Management the Chamber of Commerce of the U.S.A in Support of Respondent at 15, *Sereboff v. Mid. Atl. Med. Servs.*, 547 U.S. 356 (2006) (No. 05-260); Motion of the American Association of Health Plans, the American Benefits Council, the Blue Cross Blue Shield Association, the Chamber of Commerce of the U.S., and the Health Insurance Association of America for Leave to File a Brief as Amici Curiae and Brief of Amici Curiae in Support of Petitioners at 10, n.20, *Great-West Life & Annuity Ins. Co.*, 534 U.S. 204 (2000) (No. 99-1786); See Thomas H. Lawrence & John M. Russell, *ERISA Subrogation 3* (ABA 2000); Mark A Hofmann, *Health Plan Wins Fight Over Costs Recovery: Ruling Benefits Employers*, BUS. INS., May 22, 2006, at 27 (quoting an industry representative as asserting that "reimbursements are vital to the ability of health plans to try to keep up with rising health-care costs").

duce the costs of plan sponsorship,²³¹ then one must also acknowledge that this advantage to the plan's sponsor is offset, perhaps significantly, by the costs of collection through the current cumbersome and inefficient monitoring and litigation process. Notwithstanding its recent failed attempt at comprehensive national health care reform,²³² Congress could address the problems identified by this Article with the current state of ERISA subrogation claims after *Montanile*.

Prior to the enactment of the ACA, between 1996 and 2008 Congress successfully enacted a series of bipartisan ERISA health care policy reforms using targeted statutory amendments to address narrow, but nevertheless important, issues in national health care policy.²³³ More recently, a bipartisan Congress acting in cooperation with President Obama successfully used this targeted statutory amendment approach to address and resolve narrow, but nevertheless important, issues under the ACA by enacting the Protecting Affordable Coverage for Employees Act²³⁴ and the 21st Century Cures Act.²³⁵ We propose a similar approach to fix the problems with ERISA subrogation claims. Our targeted statutory amendment solution, presented

231. Baron and Lamb have argued that subrogated recoveries do not directly benefit the participants in a self-insured plan, but rather represent a windfall recovery to the plan's sponsoring employer, who uses the recovery to lower employer contributions for future years. See Baron & Lamb, *supra* note 43, at 333. Although Baron and Lamb tender this point as a criticism of reimbursement clause enforcement, it also supports ERISA's secondary policy purpose of encouraging employers to voluntarily sponsor employee benefit plans by reducing administrative costs. See discussion *supra* note 41 and accompanying text.

232. See *supra* note 21 and accompanying text.

233. See Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, § 101, 110 Stat. 1936, 1939; Newborns' and Mothers' Health Protection Act of 1996, Pub. L. No. 104-204, § 601, 110 Stat. 2935, 2935; Women's Health and Cancer Rights Act of 1998, Pub. L. No. 105-277, § 901, 112 Stat. 2681-436, 2681-436; Genetic Information Nondiscrimination Act of 2008, Pub. L. No. 110-233, § 101, 122 Stat. 881, 883; Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, § 511, 122 Stat. 3765, 3881.

234. Protecting Affordable Coverage for Employees Act, Pub. L. No. 114-60, 129 Stat. 543 (2015) (PACE Act). The PACE Act amended section 1304(b) of the Affordable Care Act and section 2791(e) of the Public Health Service Act to revise the definition of a "small employer" for purposes of the market reforms under title I of the Affordable Care Act and title XXVII of the Public Health Service Act. *Id.* The PACE Act generally defined a small employer as an employer who employed an average of 1-50 employees on business days during the preceding calendar year, but provided the states the option of extending the definition of small employer to include employers with up to 100 employees.

235. Pub. L. No. 114-255, § 18001, ___ Stat. ___ (2016) (Cures Act). The Cures Act created an exception to the group health plan requirements of the Affordable Care Act by permitting small employers who are not subject to the employer mandate to offer qualified small health reimbursement arrangements for full-time workers that reimburse up to \$4,950 per individual or \$10,000 per family for medical expenses or individual health insurance policy premiums.

in detail below, is intended to address two overarching concerns. First, the proposed amendment would address the arbitrary and uncertain nature of the net tort recovery for an injured plan participant by requiring the federal courts to apply the common-fund doctrine when awarding “appropriate equitable relief” for ERISA subrogation claims brought under section 502(a)(3). The proposed amendment effectively would repeal the Supreme Court’s decision in *McCutchen*²³⁶ and render plan terms to the contrary void as a matter of public policy. Second, the proposed amendment would streamline the reimbursement clause enforcement process by giving state courts concurrent jurisdiction over ERISA subrogation claims. In addition, the proposed amendment would prohibit removal of such claims to the federal courts. This requirement would permit ERISA subrogation claims to be adjudicated in the state court forum where the participant’s underlying tort action is filed, rather than bifurcating the tort–ERISA subrogation litigation into a state court tort action and a federal court claim to enforce the plan’s reimbursement clause.

A. The Proposed Amendment

Section 502(g) of ERISA²³⁷ governs the awarding of attorneys’ fees and costs in civil actions filed under section 502. Our proposed amendment would add the following new subsection (3) to section 502(g):

(3) (i) In any action under subsection 502(a)(3) of this title by a fiduciary for or on behalf of a plan seeking appropriate equitable relief against a plan participant or beneficiary to enforce the terms of a reimbursement clause in a non-insured group health plan, the court shall apply the common fund doctrine to equitably allocate attorney’s fees, costs, and expenses between the plan and the participant or beneficiary.

(ii) Definitions.

(a) The term “group health plan” shall have the meaning defined in section 607(1).

(b) The term “reimbursement clause” shall mean a group health plan term providing that if the plan advances or pays the medical expenses of or otherwise provides plan benefits to a plan partici-

236. See discussion *supra* subsection II.B.3.

237. 29 U.S.C. § 1132(g) (2012).

pant or beneficiary for injuries caused by a third party, and the plan participant or beneficiary later covers any damages or other compensation from such third party by award, judgment, settlement or otherwise, then the plan participant or beneficiary shall reimburse the plan in full for the benefits advanced, paid, or otherwise provided by the group health plan.

- (c) The term “non-insured group health plan” shall mean a group health plan that is not subject to the law of any State that regulates insurance by virtue of the application of section 514(b)(2)(B) of this title.

In addition, section 410 of ERISA²³⁸ would be amended by adding the following new subsection (c):

(c) Any reimbursement clause (as defined in subsection 502(g)(ii)(b)) in a non-insured group health plan (as defined in subsection 502(g)(3)(ii)(c)) that purports to require a plan participant or beneficiary to reimburse the plan without reduction for attorney’s fees, costs, or expenses, or otherwise purports to waive the application of the common fund doctrine in an action under section 502(a)(3) seeking appropriate equitable relief to enforce the terms of the reimbursement clause against the participant or beneficiary shall be void as against public policy.

Finally, 28 U.S.C. § 1445,²³⁹ governing nonremovable actions, would be amended to add the following new subsection (e):

(e) A civil action in any State court arising under section 502(a)(3) of the Employee Retirement Income Security Act of 1974 by a fiduciary for or on behalf of a plan seeking appropriate equitable relief against a plan participant or beneficiary to enforce the terms of a reimbursement clause in a non-insured group health plan (as such terms are defined in subsection 502(g)(3)(ii))

238. § 1110.

239. 28 U.S.C. § 1445 (2012) (section 1445). Currently, section 1445 makes nonremovable to the federal district courts only four specific types of civil actions filed in the state courts. Our proposal would add a fifth. *Id.*

may not be removed to any district court of the United States.

B. Policy Analysis of the Amendment

The amendment rejects as politically impracticable the Supreme Court's suggestion in *Montanile* that section 502(a)(3) of ERISA be amended so that actions to enforce plan terms are not limited to equitable relief.²⁴⁰ This suggestion does nothing to address the arbitrary and uncertain nature of the net tort recovery for an injured plan participant or the disincentives to the plaintiffs' personal injury bar to provide legal services to injured plan participants. As the Supreme Court stated in *McCutchen*, "[t]hird-party recoveries do not often come free: [t]o get one, an insured must incur lawyer's fees and expenses. Without cost-sharing, the insurer free rides on its beneficiary's efforts—taking the fruits while contributing nothing to the labor."²⁴¹

Our proposed amendment retains "appropriate equitable relief" as the proper remedy consistent with the Supreme Court's prior precedents, but makes targeted modifications to the statute so that ERISA subrogation litigation is more fair to injured plan participants, encourages personal injury attorneys to provide legal services to injured plan participants on a contingency-fee basis, and makes the procedure for enforcing a plan reimbursement clause more efficient for self-insured group health plans by locating the plan's ERISA subrogation claim in the same forum—usually a state court—as the participant's underlying personal injury action.

We anticipate at least two objections to our proposed amendment, but find both objections not compelling in light of the advantages gained by changing the status quo. First, if Congress adopts this statutory change, the result will be that state court judges (not the federal judiciary) primarily will be ruling on ERISA plan subrogation claims and applying the common-fund doctrine.²⁴² The competence of the state judiciary to rule on these issues should not be in question. Equitable claims for subrogation and the equitable apportionment of attorneys' fees are rooted firmly in the common law and are a garden-variety matter for the state courts, as the Supreme Court acknowledged in *McCutchen*.²⁴³ If the Supreme Court views its state court

240. See *Montanile v. Bd. of Trs. of Nat'l Elevator Indus. Health Benefit Plan*, 136 S. Ct. 651, 661 (2016).

241. *US Airways, Inc. v. McCutchen*, 133 S. Ct. 1537, 1550 (2013).

242. If federal subject matter jurisdiction exists such that the participant files to recover for personal injuries in federal district court, then the federal district court would also hear any potential claim for reimbursement by the plan.

243. See *McCutchen*, 133 S. Ct. at 1550 & n.8 (describing application of the common-fund doctrine in subrogation litigation as a "strong and uniform" common law rule).

brethren as highly well-qualified to decide these issues, objections to the contrary simply are not persuasive.

With the competency of the state court judiciary not in question, we anticipate that the major argument against our proposed amendment boils down to legislative policy, namely, that one of the core purposes of ERISA was to ensure uniformity of plan administration, and subjecting ERISA plans to interpretation by state court judges will lead to a lack of uniformity, particularly for plans that cover participants in multiple states.²⁴⁴ In response, we would be hard-pressed to improve upon the reasoning of the Second Circuit in *Wurtz v. Rawlings Co., LLC*,²⁴⁵ which rejected a similar argument:

ERISA has strong preemptive provisions, the purpose of which are to provide a uniform regulatory regime over employee benefit plans. But ERISA says nothing about subrogation provisions. ERISA neither requires a welfare plan to contain a subrogation clause nor does it bar such clauses or otherwise regulate their content. Because ERISA is silent on subrogation, our decision does nothing to disturb ERISA's goal of national uniformity in employee benefit plan regulation.²⁴⁶

Under our proposed targeted amendment, state court judges (who already have concurrent jurisdiction to hear claims for denied plan benefits²⁴⁷) will also interpret plan terms regarding a participant's reimbursement obligation.

With or without the Affordable Care Act as the law of the land, the need for reform in this highly technical area of the law remains. National health care policy should emphasize reforms that minimize, to the extent possible, the administrative costs to employers of voluntarily sponsoring and administering group health plans. The targeted statutory amendment proposed by the Article is a modest step towards achieving this important public policy objective.

244. See *FMC Corp. v. Holliday*, 498 U.S. 52, 64–65 (1990).

245. 761 F.3d 232, 244 (2d Cir. 2014), *cert. denied*, 135 S. Ct. 1400 (2015) (rejecting argument that allowing plan participants' claims under a state anti-subrogation law to proceed is contrary to ERISA's goal of ensuring national uniformity in the administration of ERISA plans).

246. *Id.* at 244–45 (quotations and citations omitted).

247. See 29 U.S.C. § 1132(e)(1) (2012).